# THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

# FISCAL YEAR 2000 ANNUAL REPORT

## MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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**Voting Member*

January 31, 2001

His Excellency Argeo Paul Cellucci
Governor of Massachusetts

The Honorable Stephen F. Lynch
Senate Chair, Joint Committee on Commerce and Labor of Massachusetts

The Honorable William G. Greene, Jr.
House Chair, Joint Committee on Commerce and Labor of Massachusetts

Dear Governor Cellucci, Senator Lynch, and Representative Greene:

On behalf of the Massachusetts Workers' Compensation Advisory Council, it is with great pleasure that I present to you our fiscal year 2000 annual report: The State of the Massachusetts Workers' Compensation System.

The Advisory Council's annual report provides a detailed analysis of the workers' compensation system in Massachusetts. Extensive summaries of the report emphasize such areas as the workers' compensation insurance market, legislative initiatives, occupational illness and injury statistics, and the operations of the Division of Industrial Accidents (DIA). The Advisory Council also identifies areas of concern and contributes definitive recommendations to enhance the workers' compensation system. Furthermore, this report distinguishes the noteworthy accomplishments of the DIA, the Division of Insurance, and other related organizations in their objectives to ameliorate this system.

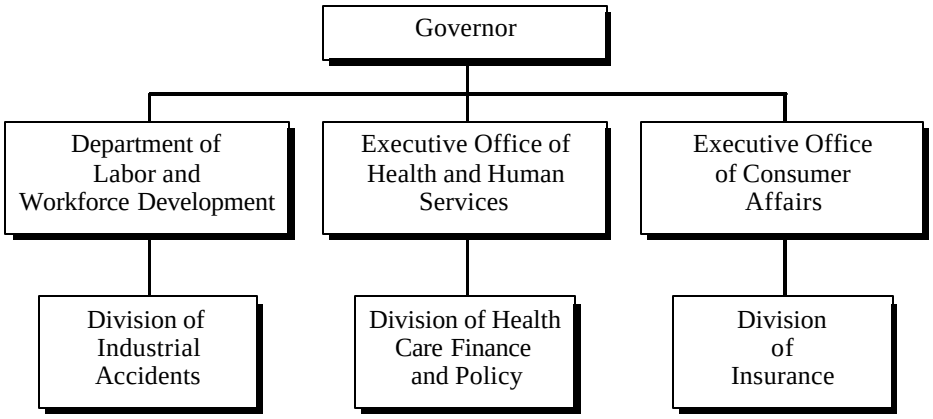
We appreciate your consideration of the Advisory Council's analysis of the state of the workers' compensation system, along with our policy positions, concerns, and recommendations. We thank you for your continued interest and support, and look forward to working with you in the future. Together, we will proceed with our mission to improve services to injured workers, employers, and all participants in the Commonwealth's workers' compensation system with unprecedented achievements.

Very truly yours,

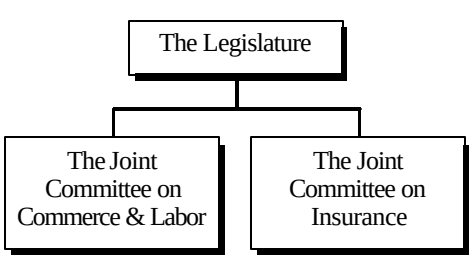
Denise A. Lucciola, M.P.H.
Executive Director

# Government Regulation of Workers' Compensation

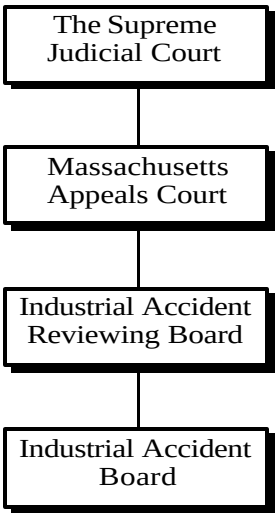
## Administrative



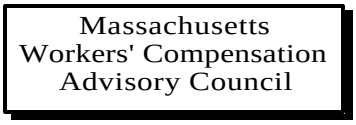

## Legislative




## Judicial




## Oversight




**Note:** The Advisory Council monitors and reports on all aspects of the workers' compensation system.

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# INTRODUCTION

# ADVISORY COUNCIL

The Massachusetts Workers' Compensation Advisory Council was created by the Massachusetts General Court on December 10, 1985, with passage of Chapter 572 of the Acts of 1985. Its functions are to monitor, recommend, give testimony, and report on all aspects of the workers' compensation system, except the adjudication of particular claims or complaints. The Council also conducts studies on various aspects of the workers' compensation system and reports its findings to key legislative and administrative officials.

The Advisory Council is mandated to issue an annual report evaluating the operations of the Division of Industrial Accidents (DIA) and the state of the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the DIA, and submit an independent recommendation when necessary. The Council also reviews the insurance rate filing and participates in insurance rate hearings.

The Advisory Council is comprised of sixteen members, appointed by the Governor for five-year terms including: five employee representatives (each of whom is a member of a duly recognized and independent employee organization); five employer representatives (representing manufacturing classifications, small businesses, contracting classifications, and self-insured businesses); one representative of the workers' compensation claimant's bar; one representative of the insurance industry; one representative of the medical providers; and one representative of vocational rehabilitation providers. The Director of the Department of Labor & Workforce Development and the Director of the Department of Economic Development serve as ex-officio members.

The employee and employer representatives comprise the voting members of the Council, and cannot take action without at least seven affirmative votes. The Council's chairperson and vice-chairperson rotate between an employee representative and an employer representative.

The Advisory Council customarily meets on the second Wednesday of each month at 9:00 a.m. at the Division of Industrial Accidents, 600 Washington Street, 7th Floor Conference Room, Boston, Massachusetts.

Meetings are open to the general public pursuant to the Commonwealth's open meeting laws (M.G.L., c.30A, §11(a)).

## Advisory Council Studies

The Analysis of Friction Costs Associated with the Massachusetts' Workers' Compensation System, Milliman & Robertson, John Lewis, (1989).

Assessment of the Department of Industrial Accidents & Workers' Compensation System, Peat Marwick Main, (1989).

Report on Competitive Rating, Tillinghast, (1989).

Report to the Legislature on Competitive Rating, Massachusetts Workers' Compensation Advisory Council, (1989).

Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, (1989).

Medical Access Study, Lynch-Ryan, The Boylston Group (1990).

Report to the Legislature on the Mark-up System for Case Scheduling, Massachusetts Workers' Compensation Advisory Council, (1990).

Report to the Legislature on Occupational Disease, Massachusetts Workers' Compensation Advisory Council, (1990).

Analysis of the Massachusetts Department of Industrial Accidents' Dispute Resolution System, Endispute, Inc., B.D.O. Seidman, (1991).

Study of Workers' Compensation Wage Replacement Rates, Tillinghast; Professor Peter Kozel, (1994).

Study of Workers' Compensation Insurance Rate Methodology, The Wyatt Company, (1994).

Competitive Rating of Workers' Compensation in Massachusetts, J.H. Albert, (1995).

Review of WC Ratemaking Concepts and WCRIBM 8/14/97 Filing, Ernst & Young LLP, (1997).

Analysis of Proposed Changes to Section 34 and 35 of Chapter 152 of the Massachusetts General Laws, Tillinghast, (1997).

Analysis of the Workers' Compensation Rating and Inspection Bureau (WCRIBM) and State Rating Bureau (SRB) Rate Filings, Tillinghast – Towers Perrin, (1999).

Addendum to the 1997 Tillinghast Analysis of Proposed Changes to Section 34 and 35 of Chapter 152 of the Massachusetts General Laws, Tillinghast, (2000)

The Advisory Council's studies are available for review Monday through Friday, 9:00 a.m. - 5:00 p.m. at the Massachusetts State Library, State House, Room 341, Boston, Massachusetts, 02133, or by appointment at the office of the Advisory Council, 600 Washington Street, 6th Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

For further information about the Massachusetts Workers' Compensation Advisory Council, visit our web page at: **http://www.state.ma.us/wcac/**.

# FISCAL YEAR 2000 IN REVIEW

After nine full years since the enactment of the workers' compensation reform act of 1991, the Massachusetts Workers' Compensation System continues to experience system-wide improvements. With filed claims at the Division of Industrial Accidents continuing to decrease, coupled with a healthy and competitive insurance market, all participants in the workers' compensation system are benefiting. Although few regulatory changes occurred in the fiscal year, the legislature is currently studying several proposals and is working closely with the Advisory Council to improve the workers' compensation system. Throughout Fiscal Year 2000, the Advisory Council carefully monitored the workers' compensation system and the operations of the DIA, seeking to recommend ways to make the system more effective and efficient.

In fiscal year 2000, the Division of Industrial Accidents continued to experience decreases in the number of workers' compensation cases filed with them. Cases filed at the DIA declined 2.1% from fiscal year 1999 level, and are down 57% since fiscal year 1991. Employee claims increased slightly by just 68 cases and have decreased by 34% as of fiscal year 1991. After nine years of consecutive decreases, insurer requests for discontinuances experienced an increase of only 25 cases. Although this represents just a slight increase, these cases have decreased by 72% since fiscal year 1991.

The insurance market continued to be extremely competitive in fiscal year 2000. A total of 8 new licenses were issued to carriers by the Division of Insurance to write workers' compensation insurance in Massachusetts. Moreover, since the implementation of new rates in September, 68 separate deviations and scheduled credits have been approved by Commissioner Linda Ruthardt of the Division of Insurance (DOI). These discounts range from 5% to 38% off manual rates, depending on the carrier and the classification. Drawn by favorable market conditions, which have been subject to continual decreases in loss costs, carriers from around the nation have entered the state in search of profitable underwriting opportunities.

In our Fiscal Year 1997 Annual Report, the Council voiced concern about the DIA's inability to verify payment of assessments collected by insurance carriers from the employers of the Commonwealth. At the April 14, 1999 Advisory Council Meeting, Council Members were informed that the Assessment Audit RFR process had been completed, and three firms had been selected. Throughout this fiscal year, as many as seven insurers were under review by the auditors. The DIA receives a monthly report from the auditors detailing the progress of these audits. Thus far, the project appears to be a success as reimbursements continue to be received by the DIA as a result of the audits.

On March 1, 1999, the Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) submitted to the Insurance Commissioner a proposal to increase average workers' compensation insurance rates by 2.6% (effective date of August 1, 1999). It was the first time in four years that the WCRIBM has filed for an increase. On March 31, 1999, the Division of Insurance held a hearing to obtain public feedback on the WCRIBM's request to increase rates by 2.6%. At the hearing, this

proposal was greeted by opposition by many parties including the State Rating Bureau (SRB) who believed that based on their preliminary analysis, no rate increase was warranted. The SRB filed their own rate filing in May, recommending that the Insurance Commissioner cut workers' compensation insurance rates by 31.7% (effective date of September 1, 1999).

Due to the vast differences in proposals by the WCRIBM and SRB, the Advisory Council worked carefully with the firm Tillinghast-Towers Perrin (Tillinghast) to provide an in-depth analysis of both rate filings. The report was divided into two sections. In the first section, Tillinghast provided an explanation of some of the key factors underlying the development of the WCRIBM's rate filing. In the second section, they included an explanation of specific elements in the SRB's rate filing, and a comparative analysis focusing on the differences in the trend methodology between the WCRIBM and SRB filings. As requested by Council Members, the Tillinghast analysis focused on the differences in loss trend between the WCRIBM and SRB filings. A final report detailing our findings was submitted to Commissioner Linda Ruthardt on July 14, 1999.

On August 24, 1999, Insurance Commissioner Linda Ruthardt issued a rate decision, which reduced average workers' compensation rates 20.3%. This rate decrease is similar to last year's rate reduction of 21.1% and continues a five-year trend of double-digit decreases, which began in 1994. The reduction became effective for policies renewed or written on and after September 1, 1999. The issued rate decision continued through Fiscal Year 2000. However, Chapter 152, §53A mandates that there must be a rate filing held at least every 2 years. Therefore, we anticipate a new rate filing by March 2001.

In November 1999, the Occupational Safety and Health Administration (OSHA) proposed an ergonomics standard in an effort to prevent hundreds of thousands of workplace injuries. Specifically, the OSHA regulation would require employers to develop and implement safety programs to protect their employees from an array of repetitive-motion injuries, including strained backs and carpal tunnel syndrome. The program would also alter state workers' compensation laws by mandating injury compensation for specific repetitive-motion injuries. The regulations would require that workers on light duty would receive full pay and benefits, and those injured would receive 90 percent of their pay and 100 percent of their benefits.

In an attempt to better understand the proposed OSHA regulations, the Advisory Council invited the Regional Director for OSHA, Frank Garvitt, to speak at the January 2000 Council meeting. Mr. Garvitt informed Council Members that OSHA's proposed regulations would cover about 28% of employees in the U.S. and would address the sector that is having about 60% repetitive stress injuries. He further explained that the proposal contained a design for small businesses, a "Quick Fix" alternative to setting up a full ergonomics program, which could remedy the problem within 90 days.

In February 2000, the Chairs of the Advisory Council and Research Analyst Andrew S. Burton attended a meeting at the State House with the Co-Chairs of the Joint Committee on Commerce & Labor to discuss workers' compensation issues for the 1999-2000 Legislative Session. The meeting allowed the Advisory Council to directly address their concerns and recommendations to members of the Committee, prior to a formal hearing on workers' compensation issues. A variety of issues were discussed including benefit

duration, scarring, timeframes for judges, code of judicial conduct, employer fines, and how to assist the OEVR unit to run more effectively. The Committee Chairs concluded the meeting by asking the Advisory Council to make an addendum to the previous benefit study with two new scenarios: §35 Benefit Duration (increase to 600 weeks) and §36 Scarring (remove the requirement of "hands, neck, and face only.")

In our Fiscal Year 1999 Annual Report, the Council expressed concern with the Office of Education and Vocational Rehabilitation (OEVR). At the Council's March 8, 2000 meeting, there was a consensus to establish a sub-committee to address certain issues that could enhance the unit's efficiency to more effectively service injured workers. The sub-committee is still proceeding with its ultimate goal of attaining an action plan for implementation. This plan will be drafted by the sub-committee and submitted to the Joint Committee on Commerce & Labor. In the interim, OEVR has disseminated two surveys to further address concerns within the provider community.

Moreover, the DIA's Legal Department assisted OEVR in the revision of 3 manuals on vocational rehabilitation procedures & services. The Rehabilitation Review Officers (RRO's) Manual was revised to ensure legal credibility and consistency within the Department. The Guidelines for Vocational Rehabilitation Providers were enhanced for providers in the community. The Informational Manual for Vocational Rehabilitation is currently in the process of being completed. This manual will be distributed to administrative law judges, administrative judges, attorneys, insurers, and the vocational rehabilitation community. This will include board decisions pertinent to OEVR procedures and demonstrate the distinctions between OEVR and the claims process. The office has also incorporated monthly review training sessions for Review Officers to assist in clarifying issues pertaining to the vocational rehabilitation process.

On June 20, 2000, Tillinghast – Towers Perrin issued a benefits analysis report at the request of the Council. This report was an updated addendum of their December 1, 1997 report Analysis of Proposed Changes to Sections 34 and 35 of Chapter 152 of the Massachusetts General Laws. Specifically, Tillinghast was commissioned by the Council to evaluate proposed changes to M.G.L. c.152, §35 (permanent partial) and §36k (bodily disfigurement) benefits. Tillinghast estimated the impacts of extending §35 benefits to 600 weeks, in addition to increasing the replacement rate to 66 2/3%. Furthermore, Tillinghast assessed the impact of revising scarring benefits to pre-1991 reform levels.

For §35 proposed scenarios, Tillinghast estimated the effects of extending the benefit duration to 600 weeks, assuming the replacement rate remains at 60%. The findings indicated that if changed, this scenario would have a 7.5% increase in system costs. Also, assuming a change in benefit duration to 600 weeks and an increase to a 66 2/3% replacement rate, the overall effect on the system would be a 9% increase in costs.

Tillinghast was unable to quantify the impact of scarring, as data is not compiled at this level of detail by the DIA, the WCRIBM nor the NCCI. Tillinghast posited that scarring data may not be collected in great detail, since the cost of collecting this data might be more significant than the actual amount that is paid out for these benefits. If that assumption is correct, Tillinghast suggested that restoration of pre-reform scarring benefits might have a relatively minimal impact on system costs.

As in previous years, the Advisory Council formed a budget subcommittee to review the DIA's Fiscal Year 2001 Spending Plan. Members of the subcommittee met with DIA officials to review each subsidiary and examined increases and decreases from the prior year's budget. On July 28, 2000, Governor Cellucci signed the General Appropriations Act, allocating the DIA a $17,815,834 operating budget for Fiscal Year 2001. This year's appropriation was $585,834 less than the DIA's original request and represents a $256,180 decrease from last year's appropriation amount. The Advisory Council worked closely with the Joint Committee on Commerce & Labor and the DIA to appropriate funds that would upgrade the Division's computer system. As a result, the Legislature allocated provisions in the DIA's appropriation to allow for the release of sufficient funds from the special fund reserve to pay for expenses associated with converting the agency's computer system from Unify to Oracle. The special fund reserve money for Oracle may only be released by an affirmative vote of seven members of the Advisory Council.

In December 1999 and July 2000, there were two new studies published by the Workers' Compensation Research Institute indicating the Massachusetts Workers' Compensation system has faster payments to injured workers and a slowing of medical cost growth. The first study, published in December 1999, Benchmarking the Performance of Workers' Compensation Systems: CompScope™ Measures for Massachusetts, also found that defense legal costs were rising by 9% annually. The second study, completed in July 2000, Benchmarking the Performance of Workers' Compensation Systems: CompScope™ Multistate Comparisions, compared the Massachusetts workers' compensation system to those of California, Connecticut, Florida, Georgia, Minnesota, Pennsylvania and Texas. In comparison to these other states, it took longer for payors to get notice of injuries, expenses for delivering benefits to workers were average, the typical worker returns to work more quickly, and litigation was higher, but defense attorney fees were lower in Massachusetts. Both of these studies are being updated to include more recent and mature data, which will allow examination of trends in indemnity and medical benefits over a longer period of time.

# CONCERNS & RECOMMENDATIONS

M.G.L. c.23 E, §17, directs the Advisory Council to include in its annual report "an evaluation of the operations of the [DIA] along with recommendations for improving the workers' compensation system." Overall, we are pleased with the workers' compensation system in Massachusetts, as reflected by reduced caseloads at the DIA, premium reductions to employers, and a competitive insurance marketplace. In an effort to both continue and build upon the success of the 1991 reforms, the Council has concluded the following areas are in need of attention, and offers recommendations for improvements.

## Conciliation to Conference Time Frame

Although the caseload at the DIA continues to decrease, the average time frame for a case to go from conciliation to conference has substantially increased since FY'96, in which the average case time frame for a case to go from conciliation to conference was 79.5 days. In FY'00, this time frame has decreased by 18 days from fiscal year 1999 to 100.2 days. Although the Council applauds the decrease for fiscal year 2000, we express concern that the time frame remains 26% higher than FY'96 levels. Furthermore, we maintain our concern with this issue as caseloads scheduled for conciliation have decreased by 18% since FY'96. Moreover, caseloads scheduled for conciliation have decreased by 50% since FY'91.

When the conciliator refers a case to conference, the computer scheduling system automatically assigns the case to an administrative judge who must maintain exclusive jurisdiction over the case throughout the conference and hearing stages.[1]

Administrative judges agree that this time frame will vary substantially from case to case. It is critical that enough time elapse so that the parties are able to develop the elements of their case. For example, a case involving complex medical issues will require substantiation of technical issues and of medical reports. Availability of expert's statements is a factor requiring adequate amounts of time. Moreover, a conference resulting from an insurer's request for discontinuance will require that the same judge who presided over the conference at the outset of the claim again preside over the discontinuance conference. The availability of the particular judge will affect the time frame.

The Advisory Council remains hopeful that guidelines will be implemented specifying the average amount of time it should take a case to progress through each stage of the dispute resolution process for the benefit of both the injured worker and the Administrative Judges. The Council recognizes the many factors that can affect case time frames (availability of judges, complexity of cases, judicial ownership, etc.) but believes that a system of benchmarking could help all parties better navigate the workers' compensation system.

[1] Judge ownership may increase time frames because of the administrative requirements it creates, but it does have positive benefits according to the judges. It creates continuity for litigants, accountability for case development, and it prevents "judge shopping".

## Employer Fines Legislation

During fiscal year 2000, the Advisory Council continued to express concern over the current flat fine of $100 per day assessed against any employer that is found to be lacking workers' compensation insurance.

This fine was established in 1987 and has not been adjusted since. Council Members have agreed that stop work orders and fine provisions found at M.G.L. c.152, §25C are not sufficiently punitive to deter employers from violating the mandate to obtain workers' compensation insurance coverage.

For the past five years, this issue has been a significant concern of the Advisory Council. In FY'97, the Advisory Council worked to develop a bill to address the inadequacy of the current fines. Council Members consulted with officials from the insurance industry, the Insurance Fraud Bureau, and the DIA. As a result of these meetings, the Council believed it was important that a fine be based on a "sliding scale." Therefore, employers that have avoided greater amounts of premium would be subject to a larger fine than employers that have avoided a smaller premium would. For this reason, the Council agreed to adopt the approach of several states that imposed fines at the rate of three times premium avoided.

The Advisory Council drafted legislation to address these concerns and former Senate Bill 1970 has been re-filed by Senator Stephen F. Lynch, Senate Chair of the Joint Committee on Commerce & Labor.

Another continuing concern of the Advisory Council is the magnitude of Trust Fund Claims. When an employee is injured at work, and it is discovered that the employer failed to provide coverage, the employee may obtain benefits through the DIA's Trust Fund. The Trust Fund was built into the statute as a protective measure to pay for the benefits of injured employees of uninsured employers. The Trust Fund is financed through assessments paid by the vast majority of employers who purchase insurance. In FY'00, approximately $3,390,180 was paid to uninsured claimants.

The Advisory Council continues to voice support for this legislation. Although this bill was reported favorably by the Joint Committee on Commerce & Labor, no action was taken by the Senate Ways & Means Committee during the 1999 – 2000 Legislative Session.

As the 2001 – 2002 Legislative Session begins, Council Members are optimistic that the Legislature will re-examine the significance of this bill that has been re-filed by Senator Lynch.

Council Members believe that passage of this bill will force fraudulent employers to purchase workers' compensation insurance and will help alleviate multiple claims against the Trust Fund. The Advisory Council strongly recommends that this bill be enacted and signed into law during the 2001 – 2002 Legislative session.

# Legislation to Stagger Judicial Terms

In fiscal year 1998, the DIA experienced delays in both conferences and hearing due to the expirations of such a large number of judicial terms. During that fiscal year, nine of twenty-four administrative judge (AJ) terms expired, as did all six administrative law judge (ALJ) terms. With as many as nine AJs and all six ALJs expiring in 2004, the Advisory Council believes that judicial term staggering legislation can prevent similar delays to the system in the future.

During the 1999-2000 Legislative Session, Representative Robert Koczera filed H. 577, which proposes to stagger the judicial terms at the DIA and would increase the number of administrative judges from 21 to 25. The bill was reported favorably by the Joint Committee on Commerce & Labor but never progressed beyond House Ways & Means. For the 2001 – 2002 Legislative session, Representative Peter J. Larkin, Chairman of the Joint Committee on Commerce and Labor, re-filed and modified this bill to reflect current judicial expiration dates.

**Section 1** of this bill would require the staggering of administrative judge appointments beginning in 2001. The intent is to avoid future problems of multiple terms expiring in one year. Terms would be staggered as follows:

**2001 -** *one* administrative judges would be appointed to a *six-year* term.
**2002 -** *one* administrative judges would be appointed to a *six-year* term.
**2003 -** *two* administrative judge would be appointed to *six-year* terms.
**2004 -** *four* administrative judge would be appointed to *six-year* terms.
- *two* administrative judge would be appointed to *five-year* terms.
- *three* administrative judge would be appointed to *four-year* terms.

**2005 -** *two* administrative judges would be appointed to *six-year* terms.
**2006 -** *four* administrative judges would be appointed to *six-year* terms.
- *two* administrative judge would be appointed to *five-year* terms.

**Thereafter -** administrative judges would be appointed to *six-year* terms.

**Section 2** of this bill would amend M.G.L. c.23E, §4 by increasing the number of permanent administrative judges' positions at the DIA from 21-25. Currently, the DIA has 24 administrative judges (21 permanent and 3 recall judges). Under the bill, the number of administrative judges from any one political party could not exceed 13, up from the current 11.

**Section 3** of this bill would amend Chapter 23E, §5 by staggering administrative law judge appointments. Terms would run as follows beginning in 2004:
*two* members or successors would be appointed to *six-year* terms.
*two* members or successors would be appointed to *five-year* terms.
*two* members or successors would be appointed to *four-year* terms.
**Thereafter**, a member/successor would be appointed or re-appointed to a six-year term.

**Section 4** of this bill would establish a performance review system by the Senior Judge of the DIA during the initial term of a newly appointed Administrative Judge, as established by §4 of Chapter 23E, who has never previously served on the Industrial Accident Board.

The Advisory Council supports the need for staggering judicial terms commencing in the year 2001. We strongly recommend that the Legislature pass the revised version of this bill. This would distribute future judicial appointments and allow the workers' compensation system to function without delays for both injured workers and insurers.

## Code of Judicial Conduct Legislation

The Council supports the need for a uniform code of judicial conduct for state administrative judges (AJs) and administrative law judges (ALJs). The authority they exercise over the fate of injured employees and employers should be tempered by clearly defined standards to ensure the fair administration of justice.

Therefore, we supported House Bill 3027, which was re-filed during the 1999 – 2000 Legislative Session by Representative Antonio F. D. Cabral. However, it is the opinion of the Council that this bill be amended to utilize the American Bar Association's (ABA) Model Code of Judicial Conduct for State Administrative Law Judges. Although the ABA code only addresses conduct for ALJs, the Council recommends that this code also be applied to AJ's. Ultimately, some minor revisions should be made to the bill's language to include both definitions of judges at the DIA. The legislation currently supports the code of judicial conduct promulgated by the Supreme Judicial Court.

## Medical Utilization Trending and Tracking System (MUTTS)

The Advisory Council continued to monitor the progress of the Medical Utilization Tracking and Trending System (MUTTS) in FY'00. MUTTS is designed to be the DIA's data monitoring system that will gather billing data from insurers and utilization review agents, allowing the Commissioner to monitor medical services, trends in costs, and patterns of treatment of injured workers. The data will be used to assess the performance of providers, insurers, utilization review programs, preferred provider arrangements and others involved in the provision of medical services to injured workers.

The last of five medical initiatives conceived in the 1991 reforms, MUTTS began its evolution in FY'93 when the DIA and two consultants began working with stakeholders to outline the scope and process for MUTTS' development. In FY'97, the DIA awarded the Center for Health Economic Research (CHER) of Waltham, MA a five-year contract to develop, test and initiate the system. By FY'00, the contractor had delivered MUTTS' code and system documentation to the DIA, setting the preliminary stage for initial insurer reporting. However, with insurers expressing resistance, and interest in medical privacy associated with electronic data reporting growing locally (as expressed in Executive Order No. 412) and nationally, the Department invited the Attorney General's attention to MUTTS in FY'01. In an effort to be certain that the scope and program elements of MUTTS were correctly developed before mandating implementation, the Department awaits the outcome of the Attorney General's review.

Per the request of the Joint Committee on Commerce and Labor, the Advisory Council's Executive Director, Denise A. Lucciola, and Research Analyst, Andrew S. Burton visited the contractor to verify the program's progress and future viability. Since that time, the Council has received quarterly reports on the continuing development of MUTTS. The Advisory Council recognizes the potential for more informed decision making with an enhanced comprehensive collection system. Monitoring trends in medical services provided to injured workers could produce exceptional benefits in the system. However, we remain concerned for MUTTS' future viability due to lack of insurer participation that could, ultimately, give rise to legal challenges. The Advisory Council continues to closely monitor the MUTTS project.

# Audit of Insurance Carrier Payments/COLA Reimbursements

M.G.L. c.152, §65 states that revenues for the Special Fund and the Trust Fund shall be raised by an assessment on all employers. The act specifies that the DIA must calculate an assessment rate which, when multiplied by an employer's standard premium, yields an employer's assessment amount. M.G.L. c.152, §65(5) also specifies that the DIA must bill self insured employers and self insurance groups for these assessments. The act states that insurance carriers, however, are responsible for billing and collecting assessments from insured employers. The act also requires that assessments must be separately stated on insurance bills and that insurance carriers must pay amounts to the DIA on a quarterly basis, no later than one month after the end of the quarter.

While the DIA bills self insurance groups and self insured employers directly for assessments, it relies on insurance carriers to self-report and pay the appropriate amounts billed and collected from employers. Since 1986, when the DIA's funding system was first implemented, these payments have never been reviewed for accuracy and have gone without audit. The DIA first identified this problem in 1994, but was unable to address it due to lack of funding.

The Advisory Council first voiced concern about the DIA's inability to verify payment of assessments collected by insurance carriers in the FY'97 Annual Report. At that time, the Council investigated several possible methodologies to verify insurer payments. Members of the Council met with officials of the Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) to determine the merits of estimating employer assessments collected, based on WCRIBM data. The process was complicated for a number of reasons; the most important being that the premium information the WCRIBM collects does not precisely match the DIA's definition of "standard premium."

The DIA formed a Procurement Management Team (PMT) in March, 1998 to investigate alternative methodologies for verifying insurer payments. The PMT determined that the most beneficial and cost-effective means of accomplishing this goal was to hire three, independent auditors to verify insurance industry's records to ensure their compliance with the assessment rates. At the April 14, 1999 Advisory Council Meeting, Council Members were informed that the Assessment Audit process had been completed. In addition, three firms had been selected through an RFR process that also included the review of reimbursements made to the DIA, pursuant to M.G.L. c.152, §34B and 452 CMR 3.03. Throughout the fiscal year, as many as seven insurers were under review by the auditors.

The Advisory Council strongly supports the DIA's continued efforts in using independent auditors to verify insurer's compliance with the collection of assessments and COLA's from employers. With over $59 million dollars collected in assessments by the agency in FY'00, the Council recognizes the importance of verifying that proper payments are made by insurers. The Advisory Council believes that this process will be beneficial to both insurers and the DIA by ensuring that proper credit and debit adjustments are applied to the respective parties.

## Office of Safety Training Grants

The Office of Safety is responsible for establishing and supervising programs that entail the education and training of employees and employers in the recognition, avoidance, and prevention of unsafe or unhealthy working conditions. To fulfill this mandate, the DIA awards grants to qualified applicants, based on a competitive selection process of Request for Response (RFR).

For the past twelve years, the Office of Safety has been funding "Occupational Safety and Health Education and Training Programs." In fiscal year 2000, the office received 66 requests and funded 43 proposals training over 25,018 employees.

Clearly, this program has been a valuable success. Safety grants have saved employers a tremendous amount of money, by focussing on the pre-injury stages of workers' compensation. Currently, the program has an annual budget of $800,000, and proposals can be submitted up to a maximum of $30,000.

The Advisory Council applauds the efforts made by the Office of Safety for providing education and training to employees on a variety of workplace safety issues. Council Members have been informed that the demand for safety grants is rising and are concerned that the Office of Safety is annually constrained to a budget of $800,000. The Advisory Council is supportive of the Office of Safety's future efforts to increase their funding, thereby allowing for more employees and employers to be educated, while attaining the ultimate goal of creating safer workplaces.

## Office of Education and Vocational Rehabilitation

The Office of Education and Vocational Rehabilitation (OEVR) oversees the rehabilitation of disabled workers' compensation recipients for successful return to work. In our Fiscal Year 1999 Annual Report, the Council expressed concern with OEVR and suggested the office take a more aggressive approach that would promptly initiate services and continue to increase the return to work of injured employees. As a result, the Council established a sub-committee to address and remedy the issues of concern. The sub-committee is still proceeding with its ultimate goal of attaining an action plan for implementation within the DIA. This plan will be formally drafted and submitted to the Joint Committee on Commerce & Labor during fiscal year 2001.

# LEGISLATION

During 1999-2000 Legislative Session, approximately forty-seven bills were filed by legislators seeking to amend the workers' compensation system (see Appendix C). Most bills concerning workers' compensation matters were referred to the Joint Committee on Commerce & Labor. Once legislation is referred to the committee, public hearings are held on the bills.

The Committee met in Executive Session on June 19, 2000 to review most of the bills proposed regarding workers' compensation legislation. At this hearing, the Committee members voted to recommend that each bill either receive a favorable rating of "ought to pass," an unfavorable rating of "ought not to pass," to order further study, or to extend it for further examination until a particular date.

The Advisory Council will continue to work with the Joint Committee on Commerce & Labor to achieve the necessary changes and continually improve the workers' compensation system.

For a list of members of the Joint Committee on Commerce and Labor, see Appendix D.

## Bills Enacted

**H.3030 -** ***DeFilippi***

**CONSTRUCTION SAFETY TRAINING (§53A)**

This bill allows for reductions in workers' compensation costs for companies who have all employees certified by the US Department of Labor's Occupational Safety and Health Administration (OSHA) 10-hour Construction Safety Course.

**H.5010 -** ***DeFilippi, Donelly, Rauschenbach, Lees, Berry*** [REDRAFT OF H.4687]

**PREMIUMS FOR SELF-INSURED GROUPS (§25G, 25O)**

This redraft of H.4687 addresses the financial disclosure requirement of self-insured workers' compensation groups. Before this legislation was enacted, self-insurance groups were required to provide the Commissioner of Insurance with a "current certified financial statement of each member, including at a minimum a balance sheet, a profit and loss statement, a statement of change in fund position, and a statement showing the combined net worth of all the members applying for coverage on the inception date of the fund. The combined net worth shall be of an amount that establishes the financial strength and liquidity of the business." Section 1 of this new law will exempt self-insurance groups from this requirement if they are composed of more than 1,000 members and have been in existence for at least five years (as of December 31, 1999) and have at all times remain in compliance with the minimum net worth requirements. Section 2 of this law would drop the requirement of those SIG's (mentioned above) to have their members experienced rated pursuant to the uniform experience rating plan which is filed by the Commissioner of Insurance.

# Bills with a "Favorable Rating"

**H.576 - *Koczera***
[REFILE]

**INSURANCE COVERAGE FOR STUDENTS – SCHOOL TO WORK PROGRAMS (§1)**

This re-filed bill (previously House 5270) treats students who are participating in a work-based experience as part of a school-to-work program (as defined in Title I of the School-to-Work Opportunities Act) as "employees" of such employers in the case of work-related injuries.

**H.577 - *Koczera***
[SIMILAR]

**STAGGERING TERMS OF INDUSTRIAL ACCIDENT BOARD AND REVIEWING BOARD JUDGES (c. 23E)**

This bill is similar to House 5042 filed last legislative session as a "late file" bill.

Section 1 of this bill would require the staggering of administrative judge appointments beginning in 1999. The intent is to avoid future problems of multiple terms expiring in one year. Terms would be staggered as follows:
**1999 -** *two* administrative judges would be appointed to *six-year* terms.
**2000 -** *four* administrative judges would be appointed to *six-year* terms.
- *one* administrative judge would be appointed to a *five-year* term.
- *one* administrative judge would be appointed to a *three-year* term.

**2001 -** *one* administrative judge would be appointed to a *six-year* term.
**2002 -** *one* administrative judge would be appointed to a *six-year* term.
**2003 -** *three* administrative judges would be appointed to *six-year* terms.
**2004 -** *four* administrative judges would be appointed to *six-year* terms.
- *one* administrative judge would be appointed to a *five-year* term.
- *two* administrative judges would be appointed to *four-year* terms.
- *two* administrative judges would be appointed to *three-year* terms.

**Thereafter -** administrative judges would be appointed to *six-year* terms.

Section 2 of this bill would amend M.G.L. c.23E, §4 by increasing the number of permanent administrative judges' positions at the DIA from 21-25. Currently, the DIA has 24 administrative judges (21 permanent and 3 recall judges). Under the bill, the number of administrative judges from any one political party could not exceed 13, up from the current 11.

Section 3 of this bill would amend Chapter 23E, §5 by staggering administrative law judge appointments. Terms would run as follows beginning in 1999:
*one* member or successor would be appointed to a *one-year* term.
*one* member or successor would be appointed to a *two-year* term.
*one* member or successor would be appointed to a *three-year* term.
*one* member or successor would be appointed to a *four-year* term.
*one* member or successor would be appointed to a *five-year* term.
*one* member or successor would be appointed to a *six-year* term.
**Thereafter**, a member or successor would be appointed or re-appointed to a six-year term.

**H.1138 -** ***Kaufman*** [NEW]

**EMPLOYEE LEASING COMPANIES – EXCLUSIVE REMEDY (§15)**

This new bill would amend §15 by barring an action at law for damages for personal injuries or wrongful death by an employee towards an employee leasing company and its client company, if each are in compliance with the requirements of Chapter 152. Currently, §15 only provides protection to "the insured person employing such employee and liable for payment of the compensation provided by this chapter for the employee's personal injury or wrongful death and said insured person's employees."

**H. 2851 -** ***Koczera, (A.I.M.)*** [REFILE]

**INSURANCE COVERAGE FOR STUDENTS - SCHOOL TO WORK PROGRAMS (§1)**

This re-filed bill (previously H.5270 and identical to H.576) treats students who are participating in a work-based experience as part of a school-to-work program (as defined in Title I of the School to Work Opportunities Act) as "employees" of such employers if they receive personal injuries arising out of and in the course of such participation.

**H.3027 -** ***Cabral, Kennedy, Swan, Murray, Tarr and Travis*** [REFILE]

**REMOVAL OF AJ'S & ALJ'S (c. 2E §8) – CODE OF JUDICIAL CONDUCT**

This re-filed bill (previously House 3763) would require the Senior Judge, the AJ's and the ALJ's to be subject to the Code of Judicial Conduct as promulgated by the SJC. The Council has supported this bill in the past. [Note: The American Bar Association has written and endorsed A Model Code of Judicial Conduct for State Administrative Law Judges. This code is based on the ethical code applicable to court judges but accounts for differences in responsibilities and powers of state administrative law judges as opposed to judges presiding in a court of law.]

**S.56 -** ***Lynch, O'Flaherty, Koczera, and Moore*** [REFILE]

**BENEFITS FOR SPECIFIC INJURIES (§36) - SCAR-BASED DISFIGUREMENT**

This bill is a refile of House 3765 and Senate 51 filed during the 1997 – 1998 session. It would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. This would require compensation for all disfigurement, whether or not scar-based, regardless of its location on the body.

Section 36(k) was amended by chapter 398 to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

**S.1970 - *Lynch***
[NEW]

**EMPLOYER FINES (§25C)- INCREASE**

This bill is a newly revised version of S.67 filed this legislative session. Changes from S.67 are in bold. Note: §4 of S.67 has been entirely eliminated.

Section 1 increases civil penalty to three times the premium the violating employer would have paid in the assigned risk pool for the entire period it operated without insurance. If the period is seven days or less, **and the employer is a merit rated employer, or the employer does not qualify for merit rating or experience rating, as determined by the workers' compensation rating and inspection bureau,** the fine imposed would total **$100** for each day the employer lacked insurance.

If said period is determined to be 7 business days or less, **and the employer is an experience rated employer, as determined by the workers' compensation rating and inspection bureau**, the employer shall pay into the private employer trust fund $250 for each day the employer failed to secure insurance or self-insurance. **An employer shall provide evidence to the department evidencing his classification or rating determination by the workers' compensation rating and inspection bureau.**

Section 2 deletes provisions, which require a higher fine for employers who appeal a stop work order, and are found to lack insurance after a hearing.

Section 3 increases the criminal fines for failure to carry insurance to $5,000 for a first offense and $10,000 for a second offense **and subsequent offenses**. It also stipulates that no finding of criminal intent is necessary to prove a violation and requires that fines be ordered in addition to restitution to be paid to the DIA Trust Fund.

Section 4 amends §65 to require that stop work order fines be deposited in the private employer trust.

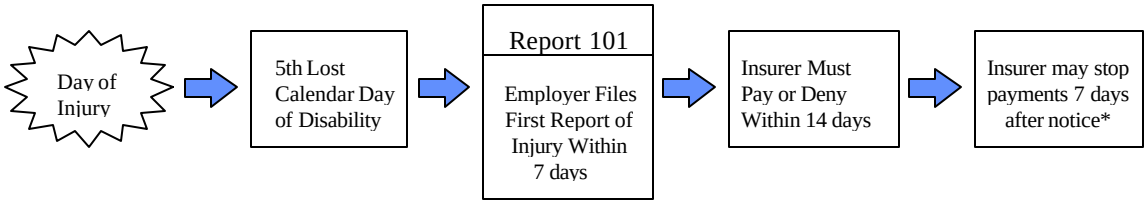
Section 5 creates a 90-day amnesty program for violating employers to obtain insurance. It requires the Commissioner of the DIA, the Commissioner of Insurance, the Insurance Fraud Bureau and the Massachusetts Workers' Compensation Rating and Inspection Bureau to implement a promotional campaign to advise employers about the amnesty period, the workers' compensation insurance requirement, and the penalties. It would also encourage the general public to report suspected violators.

# SECTION
# - 1 -
# *OVERVIEW*

# PROVISIONS TO RESOLVE DISPUTES

***Figure 1: Schedule of Events***

**Schedule of Events:**




*The insurer may stop payments unilaterally (with seven days notice) only if the case remains within the 180 day "pay without prejudice period," and the insurer has not been assigned or accepted liability for the case. Otherwise, the insurer must file a "complaint" and go through the dispute resolution process.

## Workers' Compensation Claims

When an employee is disabled or incapable of earning full wages for five or more calendar days, or dies, as the result of a work-related injury or disease, the employer must file a First Report of Injury. This form must be sent to the Office of Claims Administration at the DIA, the insurer, and the employee within seven days of notice of the injury. If the employer does not file the required First Report of Injury with the DIA, they may be subject to a fine.

The insurer then has 14 days, upon receipt of an employer's first injury report, to either pay the claim or to notify the DIA, the employer, and the employee of refusal to pay.[2] When the insurer pays a claim, they may do so without accepting liability for a period of 180 days. This is the "pay without prejudice period" that establishes a window where the insurer may refuse a claim and stop payments at its will. Up to 180 days, the insurer can unilaterally terminate or modify any claim, as long as it specifies the grounds and factual basis for so doing.[3] The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.

After a conference order is issued or the pay without prejudice period expires, the insurer may not stop payment without an order from an AJ. The insurer must request a modification or termination of benefits, based on an impartial medical exam and other statutory requirements. A discontinuance or modification of benefits may take place no sooner than 60 days following referral to the division of dispute resolution.

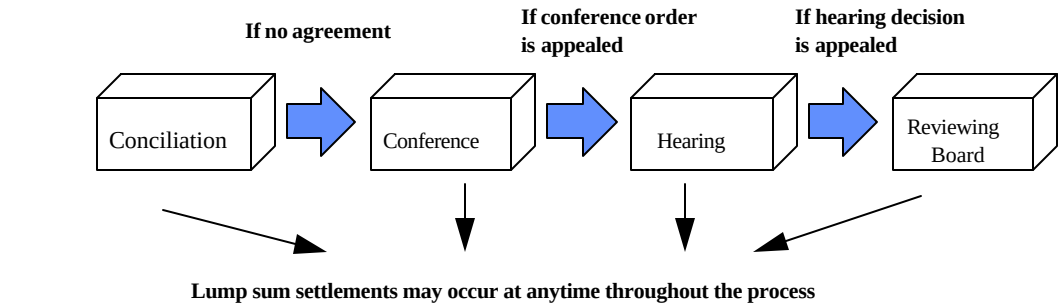
[2] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

[3] The pay without prejudice period may be extended up to one year under special circumstances. The DIA must be notified seven days in advance.

# Dispute Resolution Process

Requests for adjudication may be filed either by an employee seeking benefits or an insurer seeking modification or discontinuance of benefits following the payment without prejudice period.

***Figure 2: Dispute Resolution Process***




Dispute resolution begins at conciliation, where a conciliator will attempt to resolve a dispute by informal means. Disputes should go to conciliation within 15 days of receipt of the case from the division of administration.

A dispute not resolved at conciliation will then be referred to a conference, where it is assigned to an AJ who retains the case throughout the process if possible. The insurer must pay an appeal fee of 65% of the state average weekly wage (SAWW) or 130% of the SAWW if the insurer fails to appear at conciliation. The purpose of the conference is to compile the evidence and to identify the issues in dispute. The AJ may require both injury and hospital records. A conference order may be appealed to a hearing within 14 days.

At the hearing, the AJ reviews the dispute according to oral and written documentation. The procedure at a hearing is formal and a verbatim transcript of the proceedings is recorded by a stenographer. Witnesses are examined and cross-examined according to the Massachusetts Rules of Evidence. The AJ may grant a continuance for reasons beyond the control of any party. Either party may appeal a hearing decision within 30 days.

This time limit for appeals may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then proceed to the reviewing board, where a panel of ALJ's will hear the case.

At the reviewing board, a panel of three ALJ's will review the evidence presented at the hearing. The ALJ's may request oral arguments from both sides. They can reverse the AJ's decision only if they determine that the decision was beyond the scope of authority, arbitrary, capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an AJ for further findings of fact.

All orders from the dispute resolution process may be enforced by the Superior Court of the Commonwealth. Reviewing Board cases may also be appealed to the Appeals Court. The cost of appeals are reimbursed to the claimant (in addition to the award of the judgment), if the claimant prevails.

## Lump Sum Settlements

A case can be resolved at any point during the DIA's three-step dispute resolution process by settlement or by the decision of an administrative judge (AJ) or administrative law judge (ALJ).

Conciliators may "review and approve as complete" lump sum settlements, a standard that allows the conciliator to review a completed lump sum settlement. Conciliators or the parties at conciliation may also refer a case to a lump sum conference, where an administrative law judge will decide if a lump sum settlement is in the best interest of the parties.

AJ's, at the conference or hearing state of dispute resolution, may approve lump sum settlements in the same manner that an ALJ approves a settlement at the lump sum conference. AJ's and ALJ's must determine whether settlements are in the best interest of the employee, and they may reject a settlement offer if it appears to be inadequate. Dispute resolution begins at conciliation, where a conciliator will attempt to resolve a dispute by informal means.

## Alternative Dispute Resolution Measures

**Arbitration & Mediation** - At any time prior to five days before a conference, a case may be referred to an independent arbitrator. The arbitrator must make a decision whether to vacate or modify the compensation pursuant to M.G.L. c.251, §12 and §13. The parties involved may agree to bring the matter before an independent mediator at any stage of the proceeding. Mediation shall in no way disrupt the dispute resolution process, and any party may continue with the process at the DIA if they decide to do so.

**Collective Bargaining** - An employer and a recognized representative of its employees may engage in collective bargaining to establish certain binding obligations and procedures related to workers' compensation. Agreements are limited to the following topics: supplemental benefits under §34, 34A, 35, 36; alternative dispute resolution (arbitration, mediation, conciliation); limited list of medical providers; limited list of impartial physicians; modified light duty return to work program; adoption of a 24 hour coverage plan; establishing safety committees and safety procedures; and establishing vocational rehabilitation or retraining programs.

# SUMMARY OF BENEFITS

An employee who is injured during the course of employment or suffers from work-related mental or emotional disabilities, as well as occupational diseases, is eligible for workers' compensation benefits. These benefits include weekly compensation for lost income during the period the employee cannot work.

Indemnity payments vary, depending on the average weekly wage of the employee (AWW) and the degree of incapacitation. The statute dictates that the maximum benefit be set at 100% of the State Average Weekly Wage (SAWW) and that a minimum benefit of at least 20% of the SAWW.[4]

In addition, the insurer is required to furnish medical and hospital services, and medicines if needed. The insurer must also pay for vocational rehabilitation services if the employee is determined to be suitable by the DIA.

Below is a list of the SAWW's, since 1992, and the maximum (SAWW) and minimum benefit levels for §34 and §34A claims:

***Table 1: Indemnity Benefits***

| Effective Date | Maximum Benefit | Minimum Benefit |
|---|---|---|
| 10/1/92 | $543.30 | $108.66 |
| 10/1/93 | $565.94 | $113.19 |
| 10/1/94 | $585.95 | $117.19 |
| 10/1/95 | $604.03 | $120.81 |
| 10/1/96 | $631.03 | $126.21 |
| 10/1/97 | $665.55 | $131.11 |
| 10/1/98 | $699.91 | $131.98 |
| 10/1/99 | $749.69 | $149.93 |
| **10/1/00** | **$830.89** | **$166.18** |

**Source:** DIA Circular Letter No. 303 (October 2, 2000)

[4] The Statewide Average Weekly Wage (SAWW) is determined under M.G.L. c151A, §29(2) & promulgated by the Director the Division of Employment and Training. As of October 1, 2000, the SAWW is $830.89.

# Indemnity and Supplemental Benefits

The following are the various forms of indemnity and supplemental benefits employees may receive depending on their average weekly wage, state average weekly wage, and their degree of disability.

**Temporary Total Disability (§34)** - Compensation will be 60% of the employee's average weekly wage (AWW) before injury, while remaining above the minimum and below the maximum payments that are set for each form of compensation. The maximum weekly compensation rate is 100% of the state average weekly wage (**$830.89**), while the minimum is 20% of the SAWW (**$166.18**), if claims involve injuries occurring on or after October 1, 2000. The limit for temporary benefits is 156 weeks.

**Partial Disability (§35)** - Compensation is 60% of the difference between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits. The maximum benefits period is 260 weeks for partial disability, but may be extended to 520 weeks.

**Permanent and Total Incapacity (§34A)** - Payments will equal 2/3 of AWW following the exhaustion of temporary (§34) and partial (§35) payments. The maximum weekly compensation rate is 100% of the state average weekly wage (**$830.89**), while the minimum is 20% of the SAWW (**$166.18**), if claims involve injuries that occurred on or after October 1, 2000. The payments must be adjusted each year for cost of living allowances (COLA benefits).

**Death Benefits for Dependents (§31)** - The widow or widower that remains unmarried shall receive 2/3 of the worker's AWW, but not more than the state's AWW or less than $110 per week. They shall also receive $6 per week for each child (not to exceed $150 in additional compensation). There are also benefits for other dependents. Benefits paid to all dependents cannot exceed 250 times the state AWW plus any cost of living increases (COLA). However, children under 18 years old may continue to receive payments even if the maximum has been reached. Burial expenses may not exceed $4,000.

**Subsequent Injury (§35B)** - An employee who has been receiving compensation, has returned to work for two months or more and is subsequently re-injured, will receive compensation at the rate in effect at the time of the new injury (unless the old injury was paid in a lump sum). If the old injury was settled with a lump sum, then the employee will be compensated only if the new claim can be determined to be a new injury.

## Attorney's Fees

The dollar amounts specified for attorney's fees are listed in M.G.L. c.152, §13A(10). As of October 1, 2000, subsections 1 through 6 were updated to reflect adjustments to the State Average Weekly Wage. Below is a summary of the attorney's fee schedule:

(1) When an insurer refuses to pay compensation within 21 days of an initial liability claim but prior to a conference agrees to pay the claim (with or without prejudice), the insurer must pay an attorney's fee of **$870.35** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$435.17**.

(2) When an insurer contests a liability claim and is ordered to pay by an administrative judge at conference, the insurer must pay the employee's attorney a fee of **$1,243.36**. The administrative judge can increase or decrease this fee based on the complexity of a case and the amount of work an attorney puts in. If the employee's attorney fails to appear at a scheduled conciliation, the fee may be reduced to **$621.69**.

(3) When an insurer contests a claim for benefits other than the initial liability claim (as in subsection 1) and fails to pay compensation within 21 days, yet agrees to pay the compensation due, prior to conference, the insurer must pay the employee's attorney fee in the amount of **$621.69** plus necessary expenses. This fee can be reduced to **$310.83** if the employee's attorney fails to appear at a scheduled conciliation.

(4) When an insurer contests a claim for benefits or files a complaint to reduce or discontinue benefits by refusing to pay compensation within 21 days, and the order of the administrative judge after a conference reflects the written offer submitted by the claimant (or conciliator on the claimant's behalf), the insurer must pay the employee's attorney a fee of **$870.35** plus necessary expenses. If the order reflects the written offer of the insurer, no attorney fee should be paid. If the order reflects an amount different from both submissions, the fee should be in the amount of **$435.17** plus necessary expenses. Any fee should be reduced in half if the employee's attorney fails to show up to a scheduled conciliation.

(5) When the insurer files a complaint or contests a claim and then, either a) accepts the employee's claim or withdraws its own complaint within 5 days of a hearing, or b) the employee prevails at a hearing, the insurer shall pay a fee to the employee's attorney in the amount of **$4,351.74** plus necessary expenses. An administrative judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

(6) When the insurer appeals the decision of an administrative judge and the employee prevails in the decision of the Reviewing Board, the insurer must pay a fee to the employee's attorney in the amount of **$1,243.36**. An administrative judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

# SECTION
# - 2 -

# *WORKPLACE INJURY & CLAIM STATISTICS*

# OCCUPATIONAL INJURIES AND ILLNESSES

Every year the Massachusetts Department of Labor & Workforce Development, in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics, conducts an *Annual Survey of Occupational Injuries and Illnesses* in Massachusetts. This study surveys non-fatal injuries that occurred in the private sector workforce (not including the self-employed, farms with fewer than 11 employees, private households, and employees in Federal, State and local government agencies). A sample of 250,000 employer reports nationwide, including 10,000 in Massachusetts, are examined in an effort to represent the total private economy for 1998.

***Table 2: Injury and Illness Incidence Rates - U.S. and New England 1994-1998***

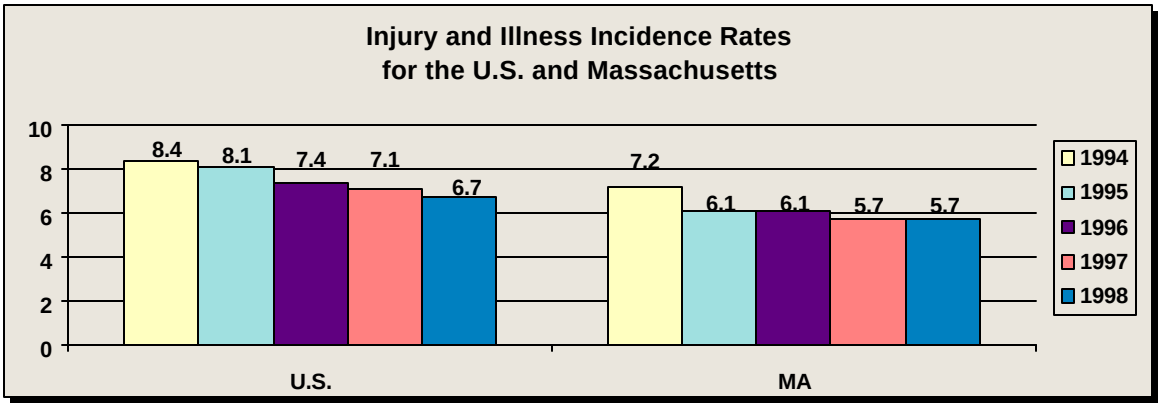
| Region | 1998 | 1997 | 1996 | 1995 | 1994 |
|---|---|---|---|---|---|
| United States | 6.7 | 7.1 | 7.4 | 8.1 | 8.4 |
| Massachusetts | 5.7 | 5.7 | 6.1 | 6.1 | 7.2 |
| Connecticut | 7.1 | 6.6 | 8.0 | 8.0 | 8.5 |
| Maine | 9.2 | 8.7 | 8.9 | 9.7 | 10.5 |
| Rhode Island | 6.7 | 7.8 | 7.1 | 8.5 | 8.5 |
| Vermont | 6.9 | 6.7 | no data | no data | 9.3 |
| New Hampshire | no data | no data | no data | no data | no data |

**Source:** Bureau of Labor Statistics - Boston Office.

## Injury Incidence Rate

In 1998, the Commonwealth averaged 2,723,400 workers in the private sector workforce. For every 100 full-time workers, 5.7 were injured in 1998 (incidence rate). For the seventh year in a row, Massachusetts ranks the lowest for incident rates among all New England states, and well below the national average of 7.1. Furthermore, this makes the Commonwealth the only New England state to remain below the national average for seven consecutive years.

***Figure 3: Injury and Illness Incidence Rates - U.S. and Massachusetts 1994-1998***




**Source:** Bureau of Labor Statistics - Boston.

***Table 3: Injury Incidence Rates by Industry - Massachusetts 1994-1998***

| Industry Division (Massachusetts) | 1994 | 1995 | 1996 | 1997 | 1998 |
|---|---|---|---|---|---|
| **Private Industry** | **7.2** | **6.1** | **6.1** | **5.7** | **5.7** |
| Agriculture, forestry, and fishing | 10.9 | 8.7 | 7.6 | 10.7 | 10.8 |
| Construction | 11.2 | 9.5 | 10.8 | 10.3 | 9.0 |
| Manufacturing | 8.1 | 7.2 | 7.3 | 7.1 | 6.6 |
| ● Durable goods | 7.3 | N/A | N/A | N/A | 6.0 |
| ● Non-durable goods | 9.4 | N/A | N/A | N/A | 7.5 |
| Transportation & public utilities | 9.3 | 8.7 | 9.0 | 8.9 | 9.3 |
| Wholesale and retail trade | 7.5 | 6.4 | 6.4 | 5.6 | 5.9 |
| ● Wholesale trade | 7.5 | N/A | N/A | N/A | 6.2 |
| ● Retail trade | 7.6 | N/A | N/A | N/A | 5.8 |
| Finance, insurance, real estate | 2.3 | 2.0 | 1.4 | 2.2 | 1.9 |
| Services | 6.8 | 5.5 | 5.4 | 5.6 | 4.9 |

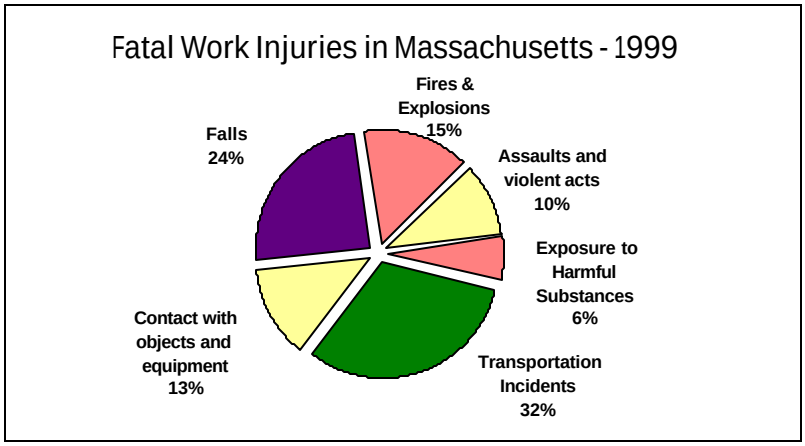
The survey also categorized incidence rates according to Massachusetts industry. Clearly, the agriculture industry had the highest overall incidence rate in 1998, with 10.8 injuries for every 100 full-time workers. Finance, insurance and real estate had the lowest incidence rates, with 1.9 injuries per 100 workers.

**Source:** Bureau of Labor Statistics - Boston.

# Fatal Work Injuries

Fatal work injuries in Massachusetts are calculated each year by the U.S. Department of Labor, Bureau of Labor Statistics. Data is taken from various states and federal administrative sources including death certificates, workers' compensation reports and claims, reports to various regulatory agencies, and medical examiner reports. In 1999, a total of 82 fatal work injuries occurred in Massachusetts, an increase of 86% from 1998 (44). This calculates to be only 1% of the 6,023 fatal work injuries nationally.

***Figure 4: Distribution of Fatal Occupational Injuries by Event - Massachusetts 1999***




Transportation incidents were the leading cause of workplace deaths in Massachusetts, accounting for 32% of the total cases in 1999. Nationally, highway crashes continued as the leading cause of on-the-job fatalities, accounting for one-fourth of the fatal work injury total in 1999.

**Source:** Bureau of Labor Statistics, Website, Released 8/17/00.

# CASE CHARACTERISTICS

The following tables and statistics illustrate trends, by injury type[5] in claims, average claim cost, and frequency for the five most recent years of available data. This data is derived from insurance claims paid by commercial insurers writing policies in the state and does not include data from self insured employers or self insurance groups (SIGs). Insurance data is not considered reliable until several years after the policy year in which the claims occurred. For this reason, the most recent year comprising of reliable data is the 1997/1998 policy year. Each year of the data is developed to the fifth report, so the years can be compared equally.

## Case Data By Injury Type

***Table 4: Developed Claim Counts (Including Large Deductibles)***

| *Composite Policy Year* | *Fatal* | *Permanent Total* | *Permanent Partial* | *Temporary Total* | *Medical Only* |
|---|---|---|---|---|---|
| **1993/94** | 42 | 30 | 5,838 | 24,558 | 70,741 |
| **1994/95** | 55 | 44 | 5,479 | 23,843 | 70,376 |
| **1995/96** | 44 | 31 | 5,405 | 23,872 | 72,061 |
| **1996/97** | 49 | 34 | 5,179 | 24,223 | 74,894 |
| **1997/98** | 58 | 41 | 6,102 | 24,405 | 76,721 |

*Source: WCRIBM, schedule Z data by injury type (developed to 5th report)*

***Table 5: Average Claim Costs - "Indemnity + Medical" (Including Large Deductibles)***

| *Composite Policy Year* | *Fatal* | *Permanent Total* | *Permanent Partial* | *Temporary Total* | *Medical Only* |
|---|---|---|---|---|---|
| **1993/94** | 217,358 | 580,279 | 49,112 | 6,736 | 329.96 |
| **1994/95** | 269,023 | 643,655 | 53,231 | 6,709 | 338.44 |
| **1995/96** | 233,536 | 504,266 | 50,053 | 7,189 | 340.68 |
| **1996/97** | 187,661 | 296,235 | 51,066 | 7,165 | 351.58 |
| **1997/98** | 211,313 | 338,223 | 50,068 | 7,480 | 380.28 |

*Source: WCRIBM, schedule Z data by injury type (developed to 5th report)*

[5] It is important to note that the WCRIBM claim categories do not correspond to specific sections of the Workers' Compensation Act. For example, the permanent total category includes predominantly section 34A benefits, but may also include benefits under section 30 and section 36.

***Table 6: Average Claim Costs - Indemnity (Including Large Deductibles)***

| Composite Policy Year | Fatal | Permanent Total | Permanent Partial | Temporary Total |
|---|---|---|---|---|
| **1993/94** | 208,904 | 386,711 | 37,452 | 4,434 |
| **1994/95** | 243,053 | 377,897 | 39,594 | 4,351 |
| **1995/96** | 222,859 | 270,741 | 37,514 | 4,708 |
| **1996/97** | 178,100 | 263,460 | 37,394 | 4,580 |
| **1997/98** | 205,705 | 274,501 | 37,588 | 4,774 |

*Source: WCRIBM, schedule Z data by injury type (developed to 5th report)*

***Table 7: Average Claim Costs - Medical (Including Large Deductibles)***

| Composite Policy Year | Fatal | Permanent Total | Permanent Partial | Temporary Total | Medical Only |
|---|---|---|---|---|---|
| **1993/94** | 8,454 | 193,568 | 11,660 | 2,302 | 329.96 |
| **1994/95** | 25,970 | 265,758 | 13,637 | 2,358 | 338.44 |
| **1995/96** | 10,677 | 233,525 | 12,539 | 2,481 | 340.68 |
| **1996/97** | 9,561 | 32,775 | 13,672 | 2,585 | 351.58 |
| **1997/98** | 5,608 | 63,722 | 12,480 | 2,706 | 380.28 |

*Source: WCRIBM, schedule Z data by injury type (developed to 5th report)*

## Claim Frequency

*Based on Developed Payroll and Developed Claim Counts*
*Unadjusted for Class Mix Changes*

***Table 8: Claim Frequency (Number of Claims per Million of Man- Weeks)***

| Composite Policy Year | Fatal | Permanent Total | Permanent Partial | Temporary Total | Medical Only |
|---|---|---|---|---|---|
| **1993/94** | 0.530 | 0.379 | 73.70 | 310.02 | 893.04 |
| **1994/95** | 0.680 | 0.545 | 68.06 | 296.16 | 874.15 |
| **1995/96** | 0.520 | 0.372 | 64.00 | 282.69 | 853.36 |
| **1996/97** | 0.560 | 0.385 | 58.88 | 275.41 | 851.53 |
| **1997/98** | 0.655 | 0.468 | 68.86 | 275.38 | 865.71 |

*Source: WCRIBM, schedule Z data by injury type (developed to 5th report)*

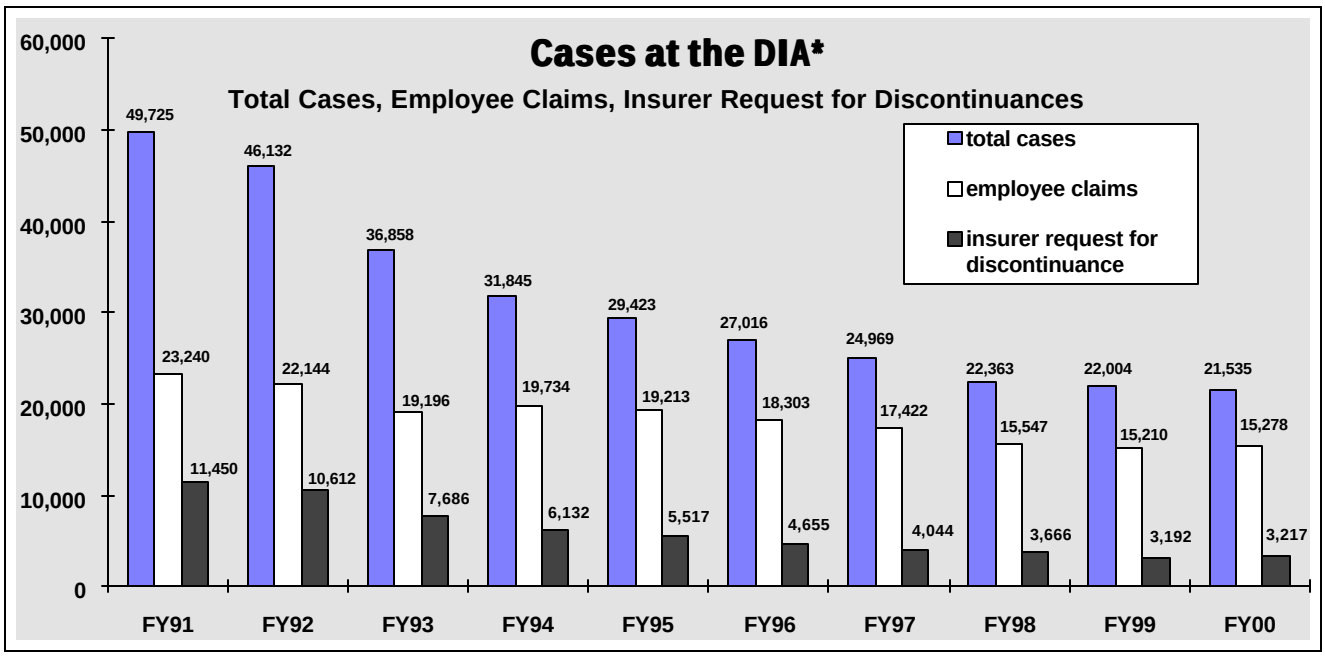
# SECTION
# - 3 -
# *DISPUTE RESOLUTION*

# DIA CASELOAD

Cases originate at the DIA when any of the following are filed: an employee's claim for benefits[6], an insurer's complaint for termination or modification of benefits[7], a third party claim[8], or request for approval of a lump sum settlement.[9]

As demonstrated in Figure 5, there has been a significant decline (57%) in the DIA caseload since implementation of the 1991 Workers' Compensation Act. Continuing a trend for the ninth straight year, "total cases" have continued to decline, decreasing by 2.1% in FY'00. Employees' claims, which account for 71% of the total cases, increased slightly by 68 cases in FY'00. Employees' claims have decrease by 34% since 1991. Also increasing slightly by 25 cases in FY'00 were insurers' requests for discontinuances. These requests have decreased by 72% since 1991.[10]

***Figure 5: Total Cases at the DIA***




**Source:** DIA report 28

***Note:** Total Cases include employee claims, insurer request for discontinuance, lump sum request, third party claims, and section 37/37A requests.

[6] DIA form 110.
[7] DIA forms 106, 107 or 108.
[8] DIA form 115.
[9] DIA form 116.
[10] DIA report 28: Statistics for sections of the law being claimed; indicates cases received for litigation.

# ADMINISTRATIVE JUDGES

DIA administrative judges (AJs) and administrative law judges (ALJs) are appointed by the Governor, with the advice and consent of the Governor's Council. Candidates for the positions are first screened by the Industrial Accidents Nominating Panel and then rated by the Advisory Council. M.G.L. c.23E allows for the appointment of 21 administrative judges and as many former judges to be recalled as the Governor deems necessary.

As one management tool to maintain a productive staff, the Senior Judge may stop assigning new cases to any judge with an inordinate number of hearing decisions unwritten. Intended as a sanction, it provides a judge who has fallen behind with the opportunity to catch up. This could become problematic if a large queue of new cases were to develop. The administrative practice of taking a judge off-line is relatively rare and occurs for limited amounts of time.

Typically, the Senior Judge will take an AJ off-line near the end of a term until reappointment is made. This enables the judges to complete their assigned hearings. Thereby, minimizing the number of cases that must be re-assigned to other judges after their term expires.

## Appointment Process

**Nominating Panel -** The nominating panel is comprised of eleven members which include: the Governor's Legal Counsel, the Director of Labor and Workforce Development, the Director of Economic Development, the DIA Commissioner, the DIA Senior Judge, and six members appointed by the Governor (two from business, two from labor, a health care provider, and a lawyer not practicing workers' compensation law). [see Appendix F for members].

When a judicial position becomes available, the nominating panel convenes to review applications for appointment and reappointment. The panel considers an applicant's skills in fact finding and the understanding of anatomy and physiology. In addition, an AJ must have a minimum of a college degree or four years of writing experience. Consideration for reappointment includes review of a judge's written decisions, as well as the Senior Judge's evaluation of the applicant's judicial demeanor, average time for disposition of cases, total number of cases heard and decided, and appellate record.

**Advisory Council Review -** The Advisory Council reviews and rates those candidates approved by the Nominating Panel. Candidates are asked to meet with Council Members for a formal interview. On the affirmative vote of at least seven voting members, the Advisory Council may rate any candidate either "qualified," "highly qualified," or "unqualified." The Council may wish to take "no position" on a candidate if consensus cannot be reached. Once a rating has been issued, it is then sent to the Governor.

# CONCILIATION

The main objective of the conciliation unit is to remove cases that can be resolved without formal adjudication from the dispute resolution system. At this stage, cases are reviewed for documentation substantiating the positions of both sides of the dispute. Conciliators are empowered to withdraw or reschedule a case until adequate documentation is presented. Approximately half of the cases that proceed through conciliation are "resolved" as a result of this process. Such resolved cases take on a broad range of dispositions including withdrawals, lump sums, and conciliated cases. The other half of the cases are referred from conciliation to a conference.

## The Conciliation Process

Conciliations are scheduled automatically by computer at the Office of Claims Administration (OCA). Attendance of both the insurer and the employee is required. The employer may attend, as well as other interested parties, with the permission of all parties. All relevant issues (including causal relationship, disability, medical condition, etc.) are reviewed at the meeting.

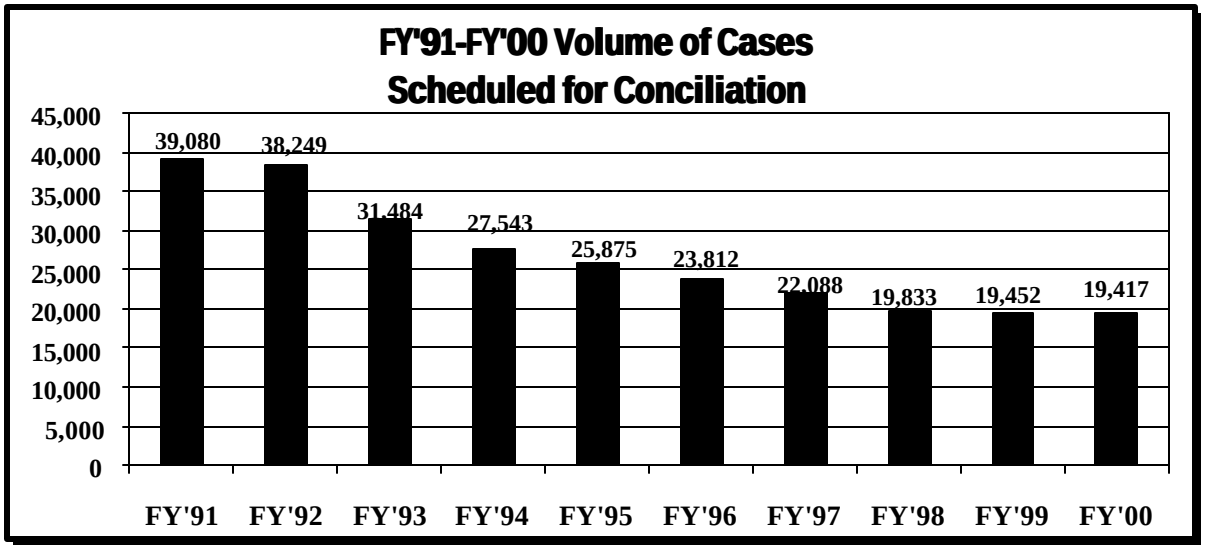
When liability is not an issue but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer fails to file, the conciliator must record the last offer made by them, or record a zero. In an effort to promote compromise, the last, best offer should indicate what each party believes the appropriate compensation rate should be.

A conciliator's recommendation is written for the case file, and the conciliator's disposition is recorded in the Diameter system.

## Volume at Conciliation

The number of cases reviewed at conciliation is indicative of the total volume of disputed claims, as nearly every case to be adjudicated must first go through conciliation. The caseload at conciliation peaked in 1991 at 39,080 cases. After the 1991 reforms, the volume of scheduled cases at conciliation has decreased every year to the current low of 19,417 cases in fiscal year 2000 (50% less than 1991 levels).

*Figure 6: Volume of Cases Scheduled for Conciliation FY'91-FY'00*




**Source:** DIA report 17

Figure 6 indicates the number of conciliations scheduled in FY'00. The volume of cases scheduled for conciliation decreased by 35 cases in FY'00. Out of the 19,417 conciliations scheduled in FY'00, 16,236 conciliations actually occurred.[11]

## Conciliation Outcomes

**Cases Referred to Conference** - Conciliation outcomes may be divided into two distinct categories: "referred to conference," or "resolved." In FY'00, 57% of the 19,417 cases scheduled for conciliation were referred to conference, the next stage of dispute resolution.[12]

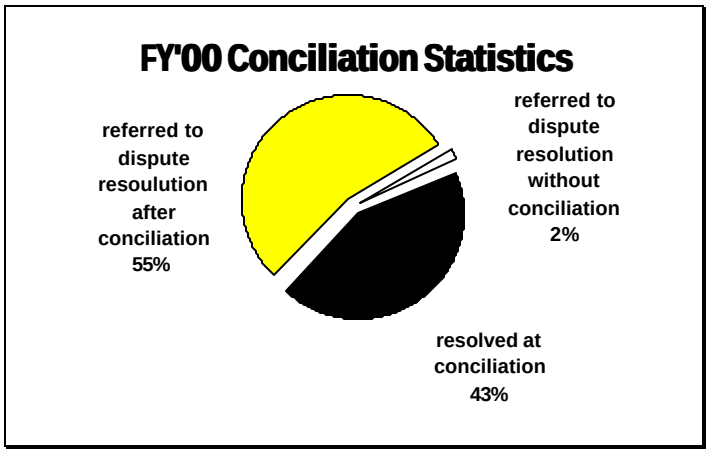
As in previous years, a small percentage (2%) of the cases scheduled for conciliation were referred to conference without conciliation. This occurs when the respondent (or party that is not putting forth the case) does not appear for the conciliation.

**Resolved Cases -** The remaining 43% of conciliation cases in FY'00 are considered to be resolved (that is they were not referred on to conference). Numbers for FY'00 are similar to previous years, although they appear to be trending downward (FY'99: 44%, FY'98: 44%, FY'97: 44%, FY'96: 45%, FY'95: 47%, FY'94: 45%, FY'93: 46%, FY'92: 49%, FY'91: 48%). While the caseload has decreased since the 1991 reforms, the percentage of cases resolved at conciliation has remained just below 50%. Cases may be withdrawn or rescheduled when information is deficient or the procedure is not followed properly, thereby, removing incomplete cases from proceeding to conference.

[11] This figure accounts for those cases withdrawn or adjusted prior to the actual conciliation. "Referred to conference" (10,628), "conciliated - adjusted" (3,346), "conciliated- pay without prejudice" (91), "withdrawn at conciliation" (1,584), "lump sum approved as complete" (175), "referred to lump sum" (412) = 16,236.

[12] DIA report 17 (Finished cases, not including reschedules).

*Figure 7: Fiscal Year 2000, Conciliation Statistics*




**Source:** DIA report 17

*Table 9: Conciliation Outcomes - FY'00 and FY'99*

| Conciliation Outcomes FY'00 and FY'99 | Number of Cases | | Percentage | |
|---|---|---|---|---|
| | FY'00 | FY'99 | FY'00 | FY'99 |
| Referred to Dispute Resolution | 11,098 | 10,830 | 57.1% | 55.7% |
| Withdrawn | 3,429 | 3,715 | 17.6% | 19.1% |
| Adjusted Prior to Conciliation | 743 | 636 | 3.8% | 3.3% |
| Lump Sum | 710 | 765 | 3.6% | 3.9% |
| Conciliated-Adjusted | 3,346 | 3,405 | 17.2% | 17.5% |
| Conciliated-Pay Without Prejudice | 91 | 101 | 0.4% | 0.5% |
| **TOTALS:** | **19,417** | **19,452** | **100%** | **100%** |

**Source:** DIA Report 17

## Resolved Cases - Conciliated

Cases may be "conciliated" by two methods. Firstly, 40% of the resolved cases (or 17% of all cases) were "conciliated-adjusted," meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. This is slightly higher than last year's percentage of "conciliated-adjusted" cases. Secondly, cases may be "conciliated - pay without prejudice" (1% of resolved cases in both FY'00 and FY'99), meaning the pay without prejudice period has been extended and the insurer may discontinue compensation without DIA or claimant approval.

## Conciliations Rescheduled

Conciliators cannot render a legal judgment on a case, but can make sure the parties have the necessary medical documentation and other sources of information to facilitate the resolution of the case. The purpose of rescheduling a case is to allow for further discussion to occur or to allow for a continuation of the case, so all the documentation

may be gathered. Out of all the cases at conciliation, 38% were rescheduled in FY'00. This is a slight decrease from the 40% of conciliations rescheduled in FY'99. Over the past several years, an upward trend in cases rescheduled at conciliation has occurred. This trend is likely a result from the greater emphasis placed on "completeness" of documentation in cases moving forward. If documentation is missing from a case at the conciliation level, it could preclude resolution later on in the dispute resolution process.

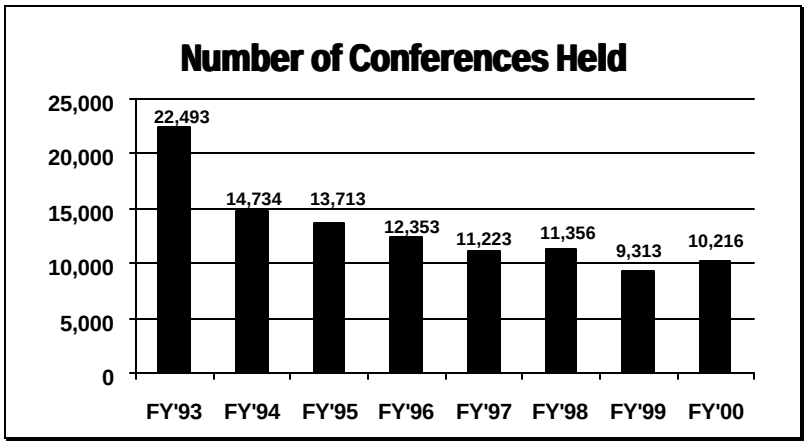
# CONFERENCE

Each case referred to a conference is assigned an administrative judge who must retain the case throughout the entire process if possible. The conference is intended to compile the evidence and to identify the issues in dispute. The administrative judge may require injury and medical records as well as statements from witnesses. In FY'00, conference orders were issued on average within 6 days of the close of the conference. The judge's conference order may be appealed within 14 days to a hearing.

## Volume of Conferences

The number of conferences held in FY'00 slightly increased by 10% (9,313 in FY'99 to 10,216 in FY'00)[13]. Historically, the number of conferences held has represented approximately half of the cases scheduled for conciliation. FY'00 numbers remain in this range, whereas in FY'93, the volume of conferences (22,493) was well above 50% of conciliations, as the backlog of cases began to diminish.

***Figure 8: Fiscal Years 1993-2000, Conferences Held***




**Source:** DIA Report 45B

## Conference Outcomes

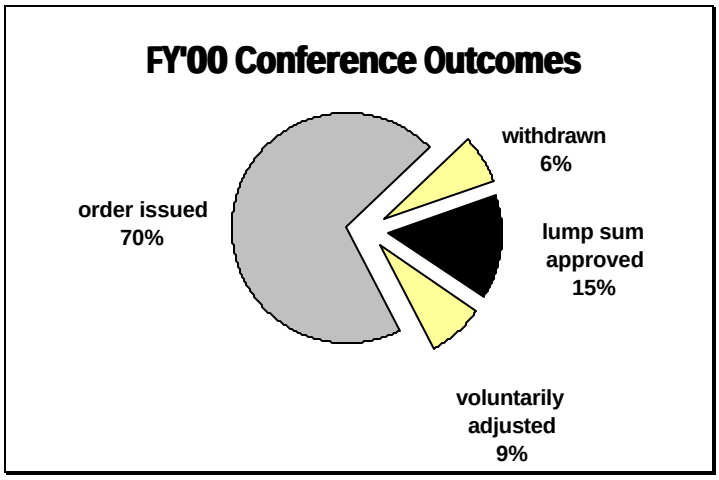
When a case is withdrawn, directed to lump sum conference, or voluntarily adjusted, it may never actually reach the conference, as it could be settled before review by the administrative judge. A case may be withdrawn at or before the conference either by the moving party or by the administrative judge, even though it was scheduled for a conference.

[13] The "order issued" disposition and the "settlement approved by judge" disposition are both final dispositions that conclude a case. "Referred to lump sum" and "voluntarily adjusted" may also be included in this category. Together, they total 10,216 conferences that took place and were completed in the year.

In a majority of conferences (70% in FY'00), the administrative judge will issue an order to modify, terminate or begin indemnity medical benefits. In fiscal year 2000, 87% of conference orders were appealed.[14]

Lump sum settlements may be approved either at a conference or a separate lump sum conference. The procedure is the same for both meetings. However, at the lump sum conference, a retired AJ whose sole purpose is to review settlements will preside over the meeting. Most lump sum settlements are approved directly at the conference or the hearing level by the presiding AJ, rather than scheduling a separate meeting. Lump sum settlements approved comprised a slightly higher percentage of the dispositions in FY'00 (14.7%) than in FY'99 (14.5%).

***Figure 9: Fiscal Year 2000, Conference Outcomes***




**Source:** DIA report 45B

***Table 10: Conference Outcomes - FY'00 and FY'99***

| Conference Outcomes FY'00 and FY'99 | Number of Cases | | Percentage | |
|---|---|---|---|---|
| | FY'00 | FY'99 | FY'00 | FY'99 |
| Withdrawn | 626 | 692 | 5.7% | 6.9% |
| Lump Sum Settlement Approved | 1,595 | 1,450 | 14.7% | 14.5% |
| Voluntarily Adjusted | 1,004 | 814 | 9.2% | 8.2% |
| Order Issued | 7,570 | 7,000 | 69.9% | 70.1% |
| Other | 20 | 29 | 0.1% | 0.3% |
| **Total** | **10,815** | **9,985** | **100%** | **100%** |

**Source:** DIA Report 45B; Conference statistics, for disposition dates (not including reschedules)

[14] DIA Report 319, "Appealed Conference Order Statistics."

## Conference Queue

The Senior Judge has explained that a conference queue of between 1,500 and 2,000 cases can be scheduled within the 12-week scheduling cycle. A queue lower than 1,500 will not provide enough cases for the judges to hear, and a queue higher than 2,000 will require changes in scheduling and assignment of cases.

The conference queue remained relatively stable throughout FY'00, ending 842 cases above the start of the year (1,699 on 7/7/99 and 2,541 on 6/28/00). The queue fluctuated throughout the year, responding to the scheduling cycle of the judges. The queue reached a high of 2,760 on 6/14/00 and a low of 844 on 1/26/00.

***Figure 10: Conference and Hearing Queues; Fiscal Years 1991 - 2000***

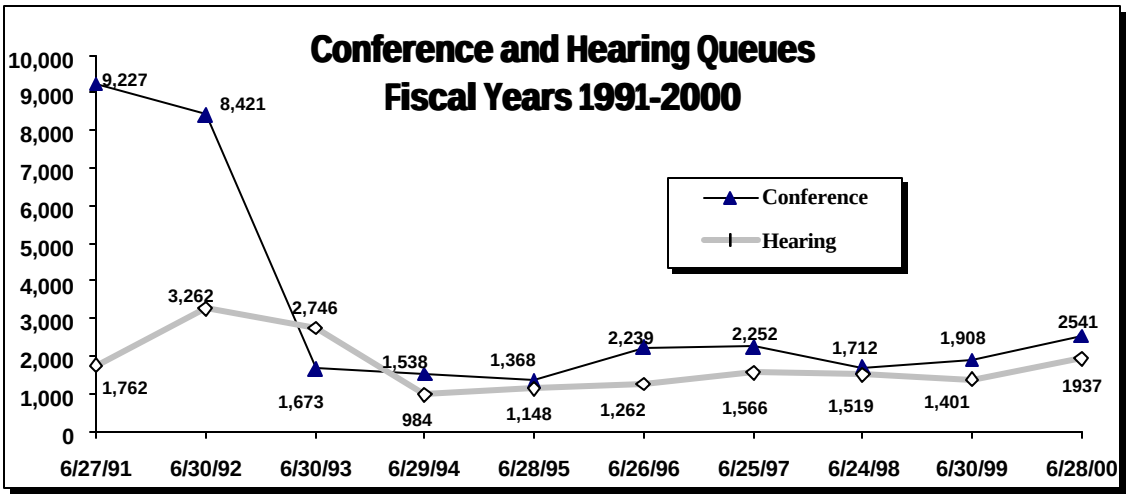
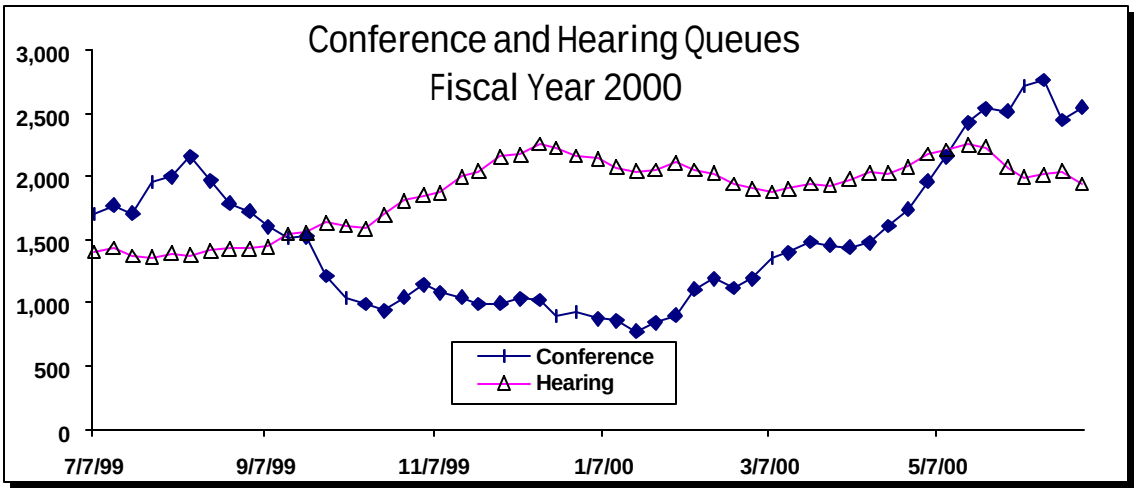



***Figure 11: Conference and Hearing Queue; Fiscal Year 2000***




**Source:** DIA report 404

# HEARINGS

According to the Workers' Compensation Act, an administrative judge that presides over a conference must review the dispute at the hearing. The procedure is formal and a verbatim transcript of the proceedings is recorded. Written documents are presented and witnesses are examined and cross-examined, according to Massachusetts Rules of Evidence. In FY'00, the average time from the beginning of a hearing to the issuance of the decision was 258 days. This is 15 days longer than the average of 243 days last fiscal year. Any party may appeal a hearing decision within 30 days. This appeal time may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then be sent to the Reviewing Board.

## Scheduling

The scheduling of hearings is more difficult than conferences because the hearing must be assigned to the judge who heard the case at the conference level. This is especially problematic since judges have different conference appeal rates. A judge with a high appeal rate will generate more hearings than a judge with a low rate of appeal. This can create difficulty in evenly distributing cases, since hearing queues may arise for individual judges with high appeal rates.

## Hearing Queue

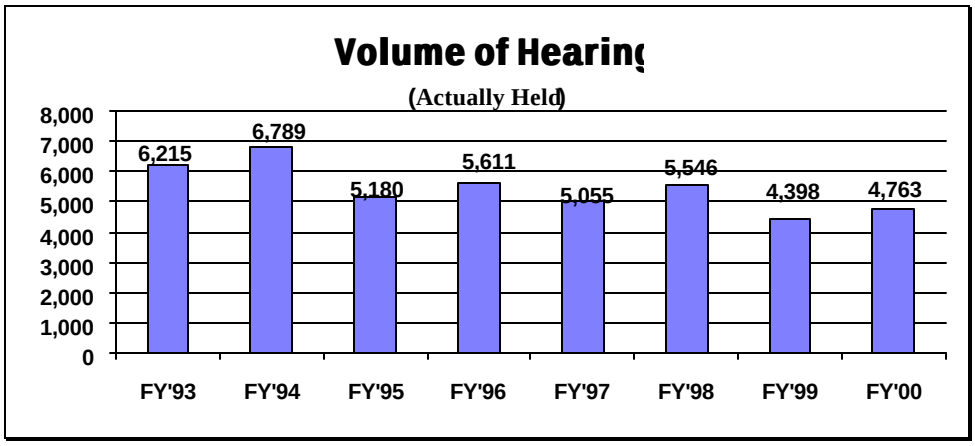
It is difficult to compare the hearing queue with the conference queue because of differences in the two proceedings. Hearings must be scheduled with the same judge who presided over the conference, whereas conferences are scheduled according to availability (when "judge ownership" is not yet a factor). Since hearings are also more time consuming than conferences, it takes more time to handle a hearing queue than a conference queue. Fiscal year 2000 began with a hearing queue of 1,399 and ended at 1,937. In the last nine years, the hearing queue has been as low as 409 cases in September 1989 and as high as 4,046 in November 1992.

## Volume of Hearings

In FY'00, there were 4,320 cases appealed to the hearing stage of dispute resolution (57% of the 7,570 conference orders) but approximately 4,763 hearings were held.[15]

[15] Dispositions included: "Voluntarily Adjusted," "Referred to Lump Sum," "Decision Filed," "Lump sum Approved/Recommended," and "Administrative Withdrawal."

*Figure 12: Fiscal Years 1993-2000, Volume of Hearings*



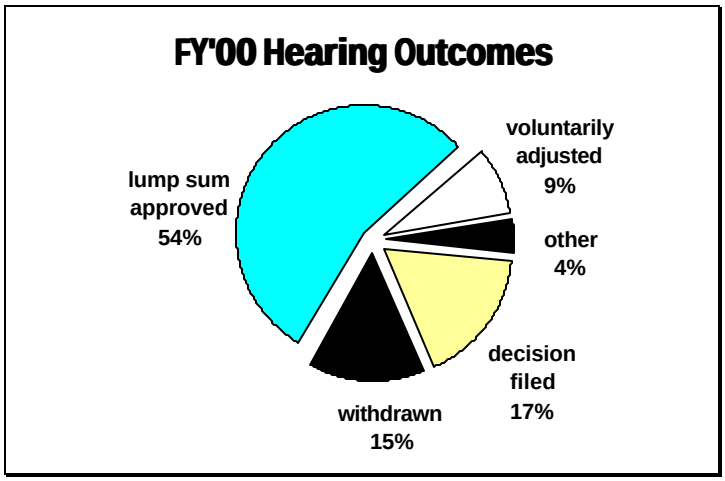

**Source:** DIA Report 346

The number of hearings "actually held" increased by 8% in FY'00 to its current level of 4,763 cases. Last year, this number decreased by 21% to 4,398 cases.

## Hearing Outcomes

The number of hearing dispositions entered in FY'00 totaled 5,765, increasing slightly from last fiscal year's total of 5,493 dispositions.[16] "Lump sums" consists of over half of all the cases, while "decision filed" accounts for only 17%, virtually the opposite of the situation at conference.

*Figure 13: Fiscal Year 2000, Hearing Outcomes*




**Source:** DIA Report 346

[16] There are usually a greater number of dispositions than the actual number of hearings because some cases have more than one disposition, others are withdrawn before the hearing, and others are from prior years.

***Table 11: Hearing Outcomes - FY'00 and FY'99***

| Hearing Outcomes FY'00 and FY'99 | Number of Cases | | Percentage | |
|---|---|---|---|---|
| | FY'00 | FY'99 | FY'00 | FY'99 |
| Withdrawn | 886 | 992 | 15.3% | 18.1% |
| Lump Sum Settlement Approved | 3,138 | 2,630 | 54.4% | 47.9% |
| Voluntarily Adjusted | 528 | 499 | 9.1% | 9.1% |
| Decision Filed | 964 | 1,193 | 16.7% | 21.7% |
| Other | 249 | 179 | 4.3% | 3.2% |
| **Total** | **5,765** | **5,493** | **100%** | **100%** |

**Source:** DIA Report 346

As in conference, lump sums may either be approved by the administrative judge at the hearing or referred to a lump sum conference that is conducted by an administrative law judge. In FY'00, 3,138 lump sum settlements were approved by a judge at hearings. The majority of lump sum settlements are approved by the AJ at a conference or hearing, since the judge is knowledgeable in the facts of the case and may decide if the settlement is in the best interest of the employee. Parties may also request to move directly to a lump sum conference rather than proceed through the conference or hearing process. This is usually indicated with a "settlement approved by judge" disposition.

# CASE TIME FRAMES

For many years, the Advisory Council has been concerned about the length of time it takes disputed workers' compensation claims to proceed through the Division of Industrial Accidents' dispute resolution process. In 1991, when the Division faced a backlog approaching 10,000 cases, there was serious concern among the participants of the system as to whether a meaningful resolution of cases could occur, when substantial delays in the system kept cases from reaching a judge at conference. For an injured worker awaiting benefits wrongfully denied, or for an insurer awaiting the go ahead to discontinue benefits, delays were found to have serious and profound economic consequences.

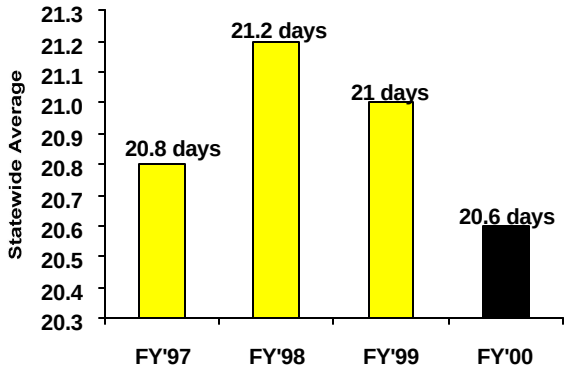
Since 1993, the DIA has been able to eliminate its backlog of cases. This was achieved by adding more judges to the DIA's division of dispute resolution, appointing a Senior Judge to manage the caseloads and assignments of the judges, utilizing management techniques to improve the functioning of the division of dispute resolution, and a substantial amount of hard work and diligent effort from the judges and their staffs.

The following case time frame statistics are taken from Diameter Report #591. The graphs illustrate the statewide time frame averages.

## Case Time Frames Guide

**Claim to Conciliation** - When an employee files an Employee's Claim form (Form 110), or the insurer files an Insurer's Notification of Denial form (Form 104), an Insurer's Notification of Acceptance, Resumption, Termination or Modification of Weekly Compensation form (Form 107), or an Insurer's Complaint for Modification, Discontinuance or Recoupment of Compensation form (Form 108), with the Division of Industrial Accidents, a conciliation is automatically scheduled.

***Figure 14: Claim to Conciliation***



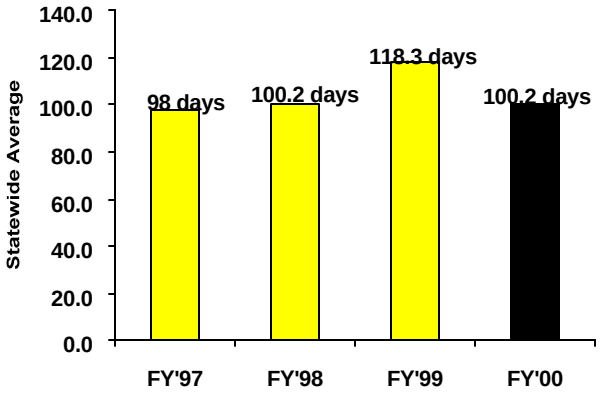

**Start** -- The day the Division receives the employee's claim for benefits, measured by the time stamp on the correspondence when the Division receives it (if there is no time stamp, the date that it is entered is used, however most claims have the date stamped).

**End** -- The day the conciliation starts.

**Conciliation to Conference** - After the conciliation, the conciliator has the option of either referring the case to conference, withdrawing the case (either for lack of adequate evidence supporting the claim or if the claim has settled), or rescheduling the conciliation to allow either party to gather adequate evidence or pursue settlement further.

When the conciliator refers a case to conference, the computer scheduling system automatically assigns the case to an administrative judge, who must maintain exclusive jurisdiction over the case throughout the conference and hearing stages.[17]

***Figure 15: Conciliation to Conference***




**Start** -- The day the conciliator enters a referral disposition for a conference.

**End** -- The start of the conference.

Administrative judges agree that this time frame will vary substantially from case to case. It is critical that enough time elapses, so that the parties are able to develop the elements of their case. For example, a case involving complex medical issues will require substantiation of technical issues and of medical reports. Availability of expert's statements is a factor requiring adequate amounts of time.

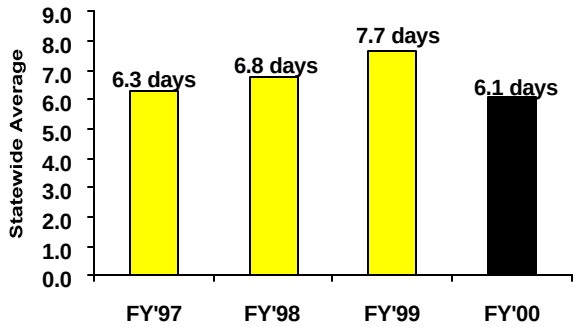
Moreover, a conference resulting from an insurer's request for discontinuance will require that the same judge, who presided over the conference at the outset of the claim, again preside over the discontinuance conference. The availability of this particular judge will affect the time frame.

**Scheduled Conference (Conference Start) to Conference Order** - At the conclusion of the conference, the administrative judge must issue a determination in the form of a conference order. The conference order is a short, written document requiring an administrative judge's initial impression of compensability, based on a summary presentation of facts and legal issues at the conference meeting. Conference orders give the parties an understanding as to how the judge might find at a full evidentiary hearing. It often provides incentives for the parties to pursue settlements or return to work arrangements.

[17] Judge ownership may increase time frames because of the administrative requirements it creates, but it does have positive benefits according to the judges. It creates continuity for litigants, accountability for case development, and it prevents "judge shopping".

It is critical to recognize that, on occasion, judges may decide to delay from issuing an order while the parties attempt to implement return to work arrangements. An administrative judge may also require that the parties define the legal and evidentiary issues by submitting written briefs. These measures may occur as an attempt to encourage resolution of the case prior to a full evidentiary hearing and may serve to lengthen the time frame in any given case. Nevertheless, successful resolution of a case will save time in future proceedings.

***Figure 16: Conference Scheduled (start) to Order***



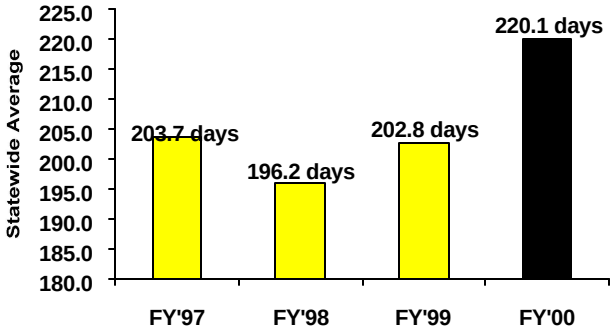

**Start** -- The first actual conference that takes place. If the scheduled conference is rescheduled, the start date will be the rescheduled conference.

**End** -- The date of the conference order.

This time frame will begin at the conference start and conclude on the date the conference order is issued. Judges may reschedule the conference to enable one or both of the parties to further develop their case by gathering additional evidence, or may issue a continuation of the conference to allow a return to work offer to be presented and verified.

**Appeal of Conference Order to Hearing** - When either party appeals a conference order by filing an *Appeal of Conference Proceeding* form (Form 121), the Division of Dispute Resolution at the DIA will schedule a hearing. Because the Workers' Compensation Act requires that the same judge who presides over the conference must also preside over the corresponding hearing, scheduling of hearings is dependent on the availability of the presiding judge. It is important to note that the rate of appeals of conference orders varies among the judges at the DIA. Since judges are available to hear only so many hearings during any particular scheduling cycle, the time frame from filing the appeal to the actual hearing will depend on the availability of the particular judge assigned to the case.

***Figure 17: Appeal of Conference Order to Hearing***




**Start --** The day the Division receives an appealed conference order to a hearing (measured by time stamped correspondence).

**End --** The day the hearing starts.

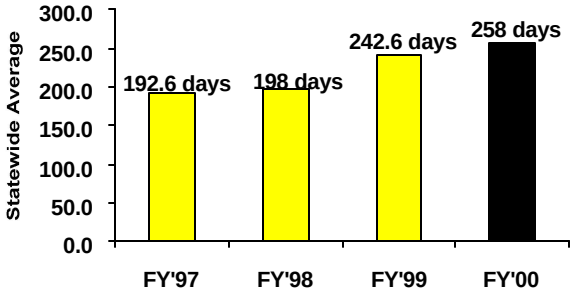
It is important to note that the shortest possible wait to hearing is not always in the best interest of either the moving or the responding party. It is often necessary that between four and six months elapse before the hearing begins to allow the medical condition of the employee to progress and stabilize. Therefore, the judge can make a determination as to the severity of injury and any earning capacity. Also, the parties need a significant period of time to prepare witnesses, testimony and evidence to present at the hearing. Finally, this period allows the employee and employers to pursue voluntary agreements.

**Scheduled Hearing (Hearing start) to the Hearing Decision -** The time between the first hearing and the hearing decision marks the distinct beginning and end points of the most lengthy, complicated and formal stage of the dispute resolution process at the DIA. Within the time period of the hearing, there are various stages through which the case may have to proceed that involve not only the judges and the respective parties, but also impartial medical examiners. Often depositions and testimony of witnesses are necessary, which require time to prepare. As in the conference, many aspects of this time frame are determined by the actions of the parties.

Cases that involve medical disputes must be evaluated by an impartial medical examiner. This involves a review of the medical record and an examination of the employee. The impartial physician is then required to submit a report.

When the impartial report is submitted by the physician, a hearing will be scheduled. In some cases, a party will wish to cross-examine the impartial physician at a deposition to clarify issues. The deposition would have to be scheduled at the convenience of the impartial physician. If the impartial medical report is found to be inadequate or too complex, then medical testimony from treating and examining physicians may be necessary. This would require the scheduling of further hearing dates.

*Figure 18: Hearing Scheduled (start) to Hearing Decision*




**Start** -- The first hearing that actually takes place (hearing start).

**End** -- The judge's secretary enters the date of the issuance of the hearing decision into the Diameter system.

Cases vary in their complexity and individual circumstances. A case involving quasi-criminal conduct (section 28), multiple insurers, parties, witnesses or injuries, or psychological stress, chemical exposure, or AIDS may take longer, require more testimony and numerous depositions of medical testimony in comparison to other less complicated cases. Moreover, the record is generally kept open by the judge for an agreed amount of time to allow for the submission of written briefs, memoranda, deposition transcripts, and hearing transcripts to assist the judge in preparing the decision. After the close of the record, the judge then must write a decision. Decisions are lengthy, as they must provide a factual determination, cite controlling board and court decisions, and provide a final determination of liability and/or compensability.

The following chart represents the average amount of time it took a case to proceed through each step of the dispute resolution process in FY'00, with respect to each district office. It is important to note that these time frames are not continuous. Therefore, their total should not be equal to the total average time frame of cases at the DIA.

*Table 12: Regional Time Frames, FY'00*

| FY'00 | Claim to Conciliation | Conciliation to Conference | Conference scheduled (start) to Order | Appeal to Hearing receipt to Hearing | Hearing scheduled (start) to Hearing decision |
|---|---|---|---|---|---|
| ***Boston*** | 20.4 days | 121.4 days | 6.4 days | 218.6 days | 253.5 days |
| ***Fall River*** | 20.6 days | 85.3 days | 7.9 days | 229.6 days | 283.7 days |
| ***Lawrence*** | 21.3 days | 85.1 days | 8.2 days | 223.6 days | 282.6 days |
| ***Springfield*** | 20.3 days | 63.2 days | 3.1 days | 197 days | 165.9 days |
| ***Worcester*** | 20.5 days | 82.8 days | 3.7 days | 235.6 days | 265.3 days |
| ***Statewide*** | **20.6 days** | **100.2 days** | **6.1 days** | **220.1 days** | **258 days** |

**Source**: DIA Report 591

# REVIEWING BOARD

The Reviewing Board consists of six administrative law judges (ALJ's) whose primary function is to review appeals of hearing decisions. While appeals are heard by a panel of three ALJ's, initial pre-transcript conferences are held by individual ALJ's. The administrative law judges also work independently to perform three other statutory duties: preside at lump sum conferences, review third party settlements (§15), and discharge and modify liens against an employee's lump sum settlement (§46A).

## Appeal of Hearing Decisions

An appeal of a hearing decision must be filed with the Reviewing Board no later than 30 days from the date of the decision. A filing fee of 30% of the state's average weekly wage, or a request for waiver of the fee must accompany any appeal.

Pre-transcript conferences are held before a single ALJ to identify and narrow the issues, to determine if oral argument is necessary and to decide if producing a transcript is necessary. This is an important step that can clarify the issues in dispute and encourage some parties to settle or withdraw the case. Approximately 20% to 25% of the cases are withdrawn or settled after this first meeting. After the pre-transcript conference, the parties are entitled to a verbatim transcript of the appealed hearing if needed.

Ultimately, cases that are not withdrawn or settled proceed to a panel of three ALJ's. The panel reviews the evidence presented at the hearing, as well as any findings of law made by the AJ. The appellant must file a brief in accordance with the board's regulations and the appellee must also file a response brief. An oral argument may be scheduled.

The vast majority of cases are remanded for further findings of fact and/or review of conclusions of law. However, the panel may reverse the administrative judge's decision, only when it determines that the decision was beyond the AJ's scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an administrative judge for further findings of fact.

The number of hearing decisions appealed to the Reviewing Board in fiscal year 2000 was 404.

***Table 13: Reviewing Board Hearing Decisions Appealed, FY'00-FY'93***

| FY'00 | FY'99 | FY'98 | FY'97 | FY'96 | FY'95 | FY'94 | FY'93 |
|---|---|---|---|---|---|---|---|
| 404 | 489 | 488 | 529 | 506 | 695 | 657 | 412 |

**Source**: DIA Reviewing Board

The Reviewing Board resolved 469 cases in FY'00 (some from the prior year) compared to 462 in the previous fiscal year.

***Table 14: Appeals Resolved by Reviewing Board, FY'00***

| *Disposition of Cases, FY'00* | *Number of Cases* |
|---|---|
| Full Panel: | 275 |
| Lump Sum Conferences: | 44 |
| Withdrawals/Dismissals for Failing to File Briefs: | 151 |
| **Total # of Appeals Resolved:** | **469** |

**Source**: DIA Reviewing Board

## Lump Sum Conferences

One recall AJ and one recall ALJ are individually assigned to preside at lump sum conferences. The purpose of the conference is to determine if a settlement is in the best interest of the employee.

A lump sum conference may be requested at any point during the dispute resolution process upon agreement of both the employee and insurer. Lump sum conferences are identical to the approval of settlements by administrative judges at the conference and hearing. Conciliators may refer cases to this lump sum conference at the request of the parties or the parties may request a lump sum conference directly.

## Third Party Subrogation (§15)

When a work related injury results in a legal liability for a party other than the employer, a claim may be brought against the third party for payment of damages. The injured employee may collect workers' compensation indemnity and health care benefits under the employer's insurance policy, and may also file suit against the third party for damages. For example, an injury sustained by an employee, as the result of a motor vehicle accident in the course of a delivery, would entitle the employee to workers' compensation benefits. The accident, however, may have been caused by another driver not associated with the employer. In this case, the employee could collect workers' compensation benefits and simultaneously bring suit against the other driver for damages.

Monies recovered by the employee in the third party action must be reimbursed to the workers' compensation insurer. However, any amounts recovered that exceed the total amount of benefits paid by the insurer may be retained by the employee.

The statute provides that the Reviewing Board may approve a third party settlement. A hearing must be held to evaluate the merits of the settlement, as well as the fair allocation of amounts payable to the employee and the insurer. Guidelines were developed to ensure that due consideration is given to the multitude of issues that arise from settlements. During FY'00, administrative law judges heard 251 section 15 petitions on a rotating basis.

## Compromise and Discharge of Liens (§46A)

Administrative law judges are also responsible to determine the fair and reasonable amount to be paid out of lump sum settlements to discharge liens under M.G.L. c.152, §46A.

A health insurer or hospital providing treatment may seek reimbursement under this section for the cost of services rendered when it is determined that the treatment provided arose from a work related injury. The Commonwealth's Department of Transitional Assistance can make a similar claim for reimbursement after providing assistance to an employee whose claim has subsequently been determined to be compensable under the workers' compensation laws.

In those instances, the health insurer, hospital, or Department of Transitional Assistance may file a lien against either the award for benefits or the lump sum settlement. When a settlement is proposed and the employee and the lien-holder are unable to reach an agreement, the ALJ must determine the fair and reasonable amount to be paid out of the settlement to discharge the lien.

The number of section 46A conferences heard in fiscal year 2000 was 108.

# LUMP SUM SETTLEMENTS

A lump sum settlement is an agreement between the employee and the employer's workers' compensation insurer, whereby the employee will receive a one-time payment in place of weekly compensation benefits. In most instances, the employer must ratify the lump sum settlement before it can be implemented. While settlements close out indemnity payments for lost income, medical and vocational rehabilitation benefits must remain open and available to the employee if needed.

Lump sum settlements can occur at any point in the dispute resolution process, whether it is before the conciliation or after the hearing. Conciliators have the power to "review and approve as complete" lump sum settlements that have already been negotiated. Administrative judges may approve lump sum settlements at conference and hearings just as an ALJ does at a lump sum conference. At the request of the parties, conciliators and administrative judges may also refer the case to a separate lump sum conference where an administrative law judge (or one of the two recall AJ's) will decide if it is in the best interest of the employee to settle.

***Table 15: Lump Sum Conference Statistics, FY'00-FY'91***

| *Fiscal Year* | *Total lump sum conferences scheduled* | *Lump sum settlements approved* |
|---|---|---|
| **FY'00** | **8,297** | **7,940 (95.7%)** |
| FY'99 | 7,900 | 7,563 (95.7%) |
| FY'98 | 9,579 | 9,158 (95.6%) |
| FY'97 | 9,293 | 8,770 (94.4%) |
| FY'96 | 10,047 | 9,633 (95.9%) |
| FY'95 | 10,297 | 9,864 (95.8%) |
| FY'94 | 13,605 | 12,578 (92.5%) |
| FY'93 | 17,695 | 15,762 (89.1%) |
| FY'92 | 18,310 | 16,019 (87.5%) |
| FY'91 | 19,724 | 17,297 (87.7%) |

**Source:** DIA report 86A: lump sum conference statistics for scheduled dates

The number of lump sum conferences has declined by 58% since FY'91. In FY'00, only 8 lump sum settlements were disapproved in the whole fiscal year. The remainder of the scheduled lump sum conferences without an "approved" disposition were either withdrawn or rescheduled.

There are four dispositions that indicate a lump sum settlement for conciliations, conferences, and hearings:

**Lump Sum Reviewed - Approved as Complete** - Pursuant to §48 of Chapter 152, conciliators have the power to "review and approve as complete" lump sum settlements when both parties arrive at conciliation with a settlement already negotiated.

**Lump Sum Approved** - Administrative judges at the conference and hearing may approve settlements, and just as an ALJ at a lump sum conference, they must determine if the settlement is in the best interest of the employee.

**Referred to Lump Sum -** Lump sums settlements may also be reviewed at a lump sum conference conducted by the recall administrative law judge or the recall administrative judge. Conciliators and administrative judges may refer cases to lump sum conferences to determine if settlement is in the best interest of the employee. Many lawyers prefer to have a case referred to a lump sum conference rather than have a conciliator approve a settlement. An ALJ renders a judgment regarding the adequacy and appropriateness of the settlement amount, whereas a conciliator merely approves an amount submitted by the attorney. This would protect the attorney from the risk of a malpractice suit.

**Lump sum request received -** A lump sum conference may also be requested after a case has been scheduled for a conciliation, conference, or hearing. The parties would fill out a form to request this event and the disposition would then be recorded as "lump sum request received." Lump sum conferences may also be requested without scheduling a meeting.

Lump sum settlement dispositions become increasingly prevalent at the later stages of the dispute resolution process as indicated in the table below.

***Table 16: Lump Sum Settlements Pursued, FY'00***

| *Meeting FY'00* | *Lump Sum Pursued*[18] | *Percentage of Total Cases Scheduled* |
|---|---|---|
| **Conciliation** | 710 | 3.6% |
| **Conference** | 1,615 | 14.7% |
| **Hearing** | 3,327 | 57.7% |

**Source**: see previous sections on conciliation, conference and hearing

[18] Lump sum pursued refers to four dispositions for lump sum settlements: lump sum request received; lump sum reviewed- approved as complete; lump sum approved; referred to lump sum conference.

# IMPARTIAL MEDICAL EXAMINATIONS

The impartial medical examination has become a significant component of the dispute resolution process, since it was created by the 1991 reform act. During the conciliation and conference stages, a disputed case is guided by the opinions of the employee's treating physician and the independent medical report of the insurer. Once a case is brought before an administrative judge at a hearing, however, the impartial physician's report is the only medical evidence that can be presented. Any additional medical testimony is inadmissible, unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed by the report.

The 1991 reforms were designed to solve the problem of "dueling doctors," which frequently resulted in the submission of conflicting evidence by employees and insurers. Prior to 1991, judges were forced to make medical judgments by weighing the report of an examining physician, retained by the insurer, against the report of the employee's treating physician.

Section 11A of the Workers' Compensation Act now requires that the Senior Judge periodically review and update a roster of impartial medical examiners from a variety of specialized medical fields. When a case involving disputed medical issues is appealed to hearing, the parties must agree on the selection of an impartial physician. If the parties cannot agree, the AJ must appoint one. An insurer may also request an impartial examination if there is a delay in the conference order.[19] Furthermore, any party may request an impartial exam to assess the reasonableness or necessity of a particular course of medical treatment, with the impartial physician's opinion binding the parties until a subsequent proceeding. Should an employee fail to attend the impartial medical examination, they risk the suspension of benefits.[20]

Under section 11A, the impartial medical examiner must determine whether a disability exists, whether such disability is total, partial, temporary or permanent, and whether such disability has as its "major or predominant contributing cause" a work-related personal injury. The examination should be conducted within 30 to 45 calendar days from assignment. Each party must receive the impartial report at least 7 days prior to the start of a hearing.

## Impartial Unit

The Impartial Unit, within the Division of Dispute Resolution, will choose a physician from the impartial physician roster when parties have not selected one or when the AJ has not appointed one. While it is rare that the Impartial Unit chooses the specialty, in most cases it must choose the actual physician. The unit is also required to collect filing fees, schedule examinations, and to ensure that medical reports are promptly filed and that physicians are compensated after the report is received.

[19] M.G.L. c.152, §8(4).
[20] M.G.L. c.152, §45.

Filing fees for the examinations are determined by the Commissioner and set by regulation through the Commonwealth's Executive Office of Administration & Finance.

The following details the department's fee schedule:

***Table 17: Fee Schedule***

| | |
|---|---|
| **$350** | Impartial medical examination and report |
| **$500** | For deposition lasting up to 2 hours |
| **$100** | Additional fee when deposition exceeds 2 hours |
| **$225** | Review of medical records only |
| **$90** | Supplemental medical report |
| **$75** | When worker fails to keep appointment (maximum of 2) |
| **$75** | For cancellation less than 24 hours before exam |

**Source**: DIA Medical Unit

The deposing party is responsible for paying the impartial examiner for services and the report. Should the employee prevail at the hearing, the insurer must pay the employee the cost of the deposition. In FY'00, $4,468 was collected in filing fees.

As of 7/1/00, there were 309 physicians on the roster consisting of 30 specialties. [21] The impartial unit is responsible for scheduling appointments with the physicians. Scheduling depends upon the availability of physicians, which varies by geographic region and the specialty sought. A queue for scheduling may arise according to certain specialties and regions in the state.

In FY'00 the impartial unit scheduled 6,871 examinations. Of these, 4,308 exams were actually conducted in the fiscal year (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or took place in the next year). [22] Medical reports are required to be submitted to the Division and to each party within 21 calendar days after completion of the examination. The number of exams scheduled in FY'99 was 4,529, and 3,460 were conducted in that year.

## Waivers of Impartial Exam Fees

In 1995, the Supreme Judicial Court ruled that the Division of Industrial Accidents must waive the filing fee for indigent claimants appealing an administrative judge's benefit-denial order. As a result of this decision, the DIA has implemented procedures and standards for processing waiver requests and providing financial relief for the section 11A fee.

[21] Including contracts pending renewal.
[22] Additional reports may be entered upon FY'00 closure.

**The Waiver Process** - A workers' compensation claimant who wishes to have the impartial examination fee waived must complete the form "Affidavit of Indigence and Request for Waiver of §11A (2) Fees" (Form 136). This document must be completed before 10 calendar days following the appeal of a conference order.

It is within the discretion of the Commissioner to accept or deny a claimant's request for a waiver, based on documentation supporting the claimant's assertion of indigency as established in 452 CMR 1.02. If the Commissioner denies a waiver request, it must be supported by findings and reasons in a Notice of Denial report. Within 10 days of receipt of the Notice of Denial report, a party can request a reconsideration. The Commissioner can deny this request without a hearing if past documentation does not support the definition of "indigent" set out in 452 CMR 1.02, or if the request is inconsistent or incomplete. If a claimant is granted a waiver and prevails at a hearing, the insurer must reimburse the Division for any fees waived.

**Definition of Indigency** -

An indigent party is defined as:

a) one who receives one of the following types of public assistance: Aid to Families with Dependent Children (AFDC), Emergency Aid to Elderly Disabled and Children (EAEDC), poverty related veteran benefits, food stamps, refugee resettlement benefits, Medicaid, or Supplemental Security Income (SSI) or

b) one whose annual income after taxes is 125% of the current federal poverty threshold (established by the U.S. Department of Health and Human Services) as referred to in M.G.L. c.261, §27A(b). Furthermore, a party may be determined indigent based on the consideration of available funds relative to the party's basic living costs.

***Table 18: Indigency Eligibility***

| Size of Family Unit | Amount |
|---|---|
| 1 | $10,438 |
| 2 | $14,063 |
| 3 | $17,688 |
| 4 | $21,313 |
| 5 | $24,938 |
| 6 | $28,563 |
| 7 | $32,188 |
| 8 | $35,813 |

**Source:** Guidelines as of 2/15/00.

For family units with more than eight members, add $3,625 for each additional member in the family. The poverty guidelines are updated annually by the U.S. Department of Health and Human Services.

# SECTION
# - 4 -
# *ADMINISTRATION*

# OFFICE OF CLAIMS ADMINISTRATION

The Office of Claims Administration (OCA) is responsible for reviewing, maintaining, and recording the massive number of forms the DIA receives on a daily basis, and for ensuring that claims forms are processed in a timely and accurate fashion. Quality control is a priority of the office, and is essential to ensure that each case is recorded in a systematic and uniform method.

The OCA consists of the processing unit, the data entry unit, the record room, and the first report compliance office. It is the responsibility of the Deputy Director of Claims Administration to answer all subpoena requests, certified mail and file copy requests, and to act as the liaison to the State Record Center.

## Claims Processing Unit / Data Entry Unit

The processing unit must open, sort, and date-stamp all mail that comes into the OCA. It then must review each form for accuracy, and return incomplete forms to the sender. Forms are then forwarded to the data entry unit.

The data entry operators enter all forms and transactions into the DIA's Diameter database. As data entry personnel update the computerized records with new forms, they review the entire record of each claim being updated; both to ensure that duplicate forms are not contained in the database and that all necessary forms have been entered properly. While quality control measures slow down the entry of cases into the system, they are necessary for accurate and complete record keeping. Forms are entered in order of priority, with the need for scheduling at dispute resolution as the main criteria. All conciliations are scheduled upon entry of a claim through the Diameter case tracking system.

In fiscal year 2000, the Office of Claims Administration received 41,299 First Report of Injury Forms, 995 less than FY'99 (42,294). The number of claims, discontinuances and third party claims decreased to 22,952, slightly less than the previous year (23,788). The total number of referrals to conciliation for the fiscal year was 18,847, which was very similar to last year's referrals (19,683).

## First Report Compliance Office & Fraud Data

All employers are required to file a First Report of Injury (Form 101) within seven days of receiving notice that an employee has been disabled for at least five days. The first report compliance office issues fines to employers who do not file the First Report form in the allotted time. Fines are $100, and are doubled if referred to a collection agency.

In fiscal year 2000, $307,660 was collected in fines, a slight decrease from the $309,032 collected in FY'99.

The office is also responsible for maintaining a database on cases discovered by the DIA, in which there is some suspicion of fraud. In fiscal year 2000, Claims Administration received five in-house referrals (telephone calls, anonymous letters or within DIA units via Diameter). Outside referrals are directly reported to the Insurance Fraud Bureau or the Attorney General's Office. Claims Administration assists the Insurance Fraud Bureau investigators on copies of suspected workers' compensation files, and receives status update letters.

## Record Room

The record room, located in DIA's Boston office, is responsible for filing, maintaining, storing, retrieving and keeping track of all files pertaining to a case in the dispute resolution process. Included in case files are copies of all briefs, settlement offers, medical records, and supporting documents that accumulate during the dispute resolution process. Couriers transfer files between the regional and Boston offices twice a week.

Records are kept in DIA's Boston office for about five years, depending on space. After this time they are brought to the State Record Center in Dorchester where they are kept for 80 years.

# OFFICE OF EDUCATION AND VOC. REHAB

The Office of Education and Vocational Rehabilitation (OEVR) oversees the rehabilitation of disabled workers' compensation recipients for successful return to work.

While OEVR seeks to encourage the voluntary development of rehabilitation services, it has the authority to mandate services for injured workers determined to be suitable for rehabilitation. Vocational rehabilitation (VR) is defined by the act as "non-medical services reasonably necessary at a reasonable cost to restore a disabled employee to suitable employment as near as possible to pre-injury earnings. Such services may include vocational evaluation, counseling, education, workplace modification, and retraining, including on-the-job training for alternative employment with the same employer, and job placement assistance."[23]

A claimant is eligible for vocational rehabilitation services, when injury results in a functional limitation prohibiting a return to previous employment, or when the limitation is permanent or will last an indefinite period of time. Liability must be established in every case, and the claimant must be receiving benefits.

## The Vocational Rehabilitation System

It is the responsibility of OEVR to identify those disabled workers' who may benefit from rehabilitation services. OEVR identifies rehabilitation candidates according to injury type after liability has been established, and through referrals from internal DIA sources (including the Office of Claims Administration and the division of dispute resolution), insurers, certified providers, attorneys, hospitals, doctors, employers and injured employees themselves.[24]

Rehabilitation review officers (RRO's) interview prospective candidates during a "mandatory meeting," for the purpose of determining whether or not an injured worker is suitable for VR services. If suitability is determined, RRO's will request that the insurer assign a provider (approved by OEVR) to the injured worker so that an Individual Written Rehabilitation Program (IWRP) can be developed. RRO's then monitor all IWRP's to ensure the quality and cost-effectiveness of the provider's services. Occasionally the RRO will conduct a "team" meeting with all parties to identify problems and redirect the process towards a successful conclusion.

[23] M.G.L. c.152, §1(12).
[24] M.G.L. c.152, §30 E-H. 452 C.M.R. 4.00

Each year, OEVR approves vocational rehabilitation specialists to develop and implement the individual written rehabilitation plans (IWRP). The standards and qualifications for a certified provider are found in the regulations, 452 C.M.R. 4.03. Any state vocational rehabilitation agency, employment agency, insurer, self-insurer, or private vocational rehabilitation agency may qualify to perform these services.

Credentials must include at least a master's degree, rehabilitation certification, or a minimum of 10 years of experience. A list of the providers is available from the OEVR. In FY'00, OEVR approved 65 VR providers. It is the responsibility of the provider to submit progress reports on a regular basis, so that the RRO can have a clear understanding of the progress a case has made. Progress reports must include the following:

1. Status of vocational activity;
2. Status of IWRP development (including explanation if IWRP has not been completed within 90 days);
3. If client is retraining, copy of grades received from each marking period and other supportive data (such as attendance);
4. Summary of all vocational testing used to help develop an employment goal and a vocational goal;
5. The name of the OEVR review officer.

**Determination of Suitability** - Once an injured worker has been referred to OEVR, an initial mandatory interview between the injured worker and the rehabilitation review officer is scheduled. During this meeting, the RRO obtains basic case information from the client, explains the VR process (including suitability, employment objectives in order of priority, client rights, and OEVR's role in the process) and answers any questions the client may have. The failure of an employee to attend the mandatory meeting can result in the discontinuance of benefits until the employee complies.

Once a "mandatory meeting" has concluded, it is the duty of the RRO to issue a decision on the appropriateness of the client for vocational rehabilitation services. This is done through a Determination of Suitability (DOS) Form. Suitability is determined by a number of factors including: medical stability, substantial functional limitations, feasibility and cost-effectiveness of services, and liability must be established. If a client is deemed "suitable," the RRO will write to the insurer and request VR services for the injured worker. The insurer must then choose any OEVR-approved provider and must submit to OEVR any pertinent medical records within 10 days. If a client is deemed "unsuitable," the insurer can refer the client again after six months has elapsed.

At any point during the OEVR process after an injured worker has been found suitable for VR services, a RRO can schedule a "team meeting" to resolve issues of disagreement among any of the represented parties. All parties are invited and encouraged to attend team meetings. At the conclusion of the meeting, if parties are still in disagreement, the RRO can refer the matter back to the parties with recommendations and an action plan. All team meetings are summarized in writing.

**Individual Written Rehabilitation Program (IWRP) -** After an employment goal and vocational goal has been established for the injured worker, an Individual Written Rehabilitation Program (IWRP) can be written. The IWRP is written by the vocational provider and includes the client's vocational goal, the services the client will receive to obtain that goal, and explanation why the specific goal and services were selected, and the signatures necessary to implement it. A vocational rehabilitation program funded voluntarily by the insurer has no limit of length, however OEVR-funded programs are limited to 52 calendar weeks for pre-12/23/91 injuries and 104 calendar weeks for post-12/23/91 injuries. The IWRP should follow OEVR's priority of employment goals:

1. Return to work with same employer, same job modified;
2. Return to work with same employer, different job;
3. Return to work with different employer, similar job;
4. Return to work with different employer, different job;
5. Retraining.

In order for an IWRP to be successful, it needs to be developed jointly with the client and the employer. An IWRP with the specific employment goal of permanent, modified work must include:

a) a complete job description of the modified position (including the physical requirements of the position);
b) a letter from the employer that the job is being offered on a permanently modified basis;
c) a statement that the client's treating physician has had the opportunity to review and comment on the job description for the proposed modified job.

Before any vocational rehabilitation activity begins, the IWRP must be approved by OEVR. Vocational Rehabilitation is successful when the injured worker completes a VR program and is employed for 60 days. A "Closure Form" must then be signed by the provider and sent to the appropriate RRO. Closures should meet the following criteria:

1) all parties should understand the reasons for case closure;
2) the client is told of the possible impact on future VR rights;
3) the case is discussed with the RRO;
4) a complete closure form is submitted by the provider to OEVR; and
5) the form should contain new job title, DOT code, employer name and address, client wage, and the other required information.

**Lump Sum Settlements** - An employee obtaining vocational rehabilitation services must seek the consent of OEVR before a lump sum settlement can be approved. In the past, disabled and unemployed workers have settled for lump sum payments without receiving adequate job training or education on how to find employment. Settlement money would run out quickly and employees would be left with no means of finding suitable work. OEVR tries to have disabled employees initiate, if not complete, rehabilitation before the lump sum settlement is approved. Nevertheless, OEVR will consent to a lump sum settlement if the insurer agrees to continue to provide rehabilitation benefits.

## Utilization of Vocational Rehabilitation

In fiscal year 2000, OEVR was headed by a Director and staffed by 12 Rehabilitation Review Officers, 7 Disability Analysts, and 5 Clerks.

Out of the 2,782 cases referred to OEVR in FY'00, 81% proceeded to a "mandatory meeting" for a determination of suitability for vocational rehabilitation services. The remaining 19% exited the system for reasons that include the non-establishment of liability or that the employee was not on compensation. Of those cases, which received a "mandatory meeting," 41% were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR certified provider. In FY'00, the 62.5% success ratio of those injured workers who completed plans and returned to work matched last year's all time high.

***Table 19: Utilization of Voc. Rehab. Services, FY'92 - FY'00***

| *Fiscal Year* | *Referrals to OEVR* | *Mandatory/ Inform. Meetings* | *Referrals to Insurer for VR* | *IWRPs approved* | *Return to work* | *% RTW after plan development* |
|---|---|---|---|---|---|---|
| FY'00 | 2,782 | 2,245/227 | 911 | 514 | 318 | 62.5% |
| FY'99 | 2,939 | 2,236/227 | 951 | 546 | 341 | 62.5% |
| FY'98 | 3,011 | 2,422/236 | 1,040 | 603 | 371 | 61.5% |
| FY'97 | 3,266 | 2,455/292 | 1,094 | 690 | 320 | 46% |
| FY'96 | 3,347 | 2,653/119 | 1,185 | 727 | 364 | 50% |
| FY'95 | 3,219 | 2,833 | 1,370 | 811 | 391 | 48% |
| FY'94 | 3,756 | 3,190 | 1,706 | 948 | 470 | 50% |
| FY'93 | 4,494 | 3,882 | 2,253 | 1,078 | 554 | 51% |
| FY'92 | 6,014 | 3,367 | 2,106 | 1,010 | 583 | 58% |

**Source:** DIA - OEVR

## Trust Fund Payment of Vocational Rehabilitation

When an insurer refuses to pay for vocational rehabilitation services after a review, OEVR then determines that the employee is suitable for services and the office may utilize moneys from the Trust Fund to finance the rehabilitation services.

Fiscal Year 2000 encumbrances of the Trust Fund totaled $16,215.00 for vocational rehabilitation services.[25] OEVR is required to seek reimbursement from the insurer when the trust fund pays for the rehabilitation and the services are deemed successful (e.g., the employee returns to work). The DIA may assess the insurer a minimum of two times the cost of the services.

[25] A total of $2,836.90 was reimbursed to the Fund when an insurer agreed to reimburse the trust fund for monies spent on an active ongoing vocational rehabilitation case.

# OFFICE OF SAFETY

The function of the Office of Safety is to reduce work related injury and illnesses by "establishing and supervising programs for data collection on workplace injuries and for the education and training of employees and employers in the recognition, avoidance and prevention of unsafe or unhealthy working conditions in employment and advising employees and employers on these issues."[26] In pursuit of this objective, the office administers the DIA's Occupational Safety and Health Education and Training Program.

The office issues a request for proposals yearly to notify the general public that these grants are available. Grants are awarded on a competitive basis according to the scope and content of proposals.

See Appendix J for a list of proposals recommended for funding in FY'01.

## Safety and Education Training

The Office of Safety provides Occupational Safety and Health Safety and Education Training for employees and/or employers of industries operating within the Commonwealth and whose entire staff is covered under the Massachusetts Workers' Compensation Law (M.G.L. c.152).

The overall objective of the education and training programs is to reduce work related injuries and illnesses by establishing and supervising programs for data collection on workplace injuries, along with:

A. Identify, evaluate, and control safety and health hazards in the workplace;

B. Foster activities by employees/employers to prevent workplace accidents, injuries, illnesses;

C. Make employees/employers aware of all federal and state health and safety standards, statutes, rules and regulations that apply, including those that **mandate** training and education in the workplace;

D. Refer employees/employers to the appropriate agency for abatement procedures for safety and health related issues;

E. Target preventive educational programs for specifically identified audiences with significant occupational health and/or safety problems;

F. Encourage awareness and compliance with federal and/or state occupational safety and health standards and regulations;

G. Promote understanding among employee and employer groups of the importance of ongoing safety health education and training programs and help to begin such efforts;

[26] M.G.L. c.23E, §3(6).

H. Encourage labor/management cooperation in the area of occupational safety and health prevention programs; and

I. Encourage collaborations between various groups, organizations, educational or health institutions to devise innovative preventive methods for addressing occupational health and safety issues.

## Request for Response (RFR) Process

During the past twelve fiscal years, the Massachusetts Division of Industrial Accidents (DIA) has issued its RFR for the Office of Safety's "Occupational Safety and Health Education and Training Program." To date, the Division has funded a total of 391 preventive training programs targeting a wide variety of workers and industries within the Commonwealth. These DIA programs have trained over 127,000 people.

The Office of Safety publishes an RFR annually to notify the general public that grants are available. The program has an annual budget of $800,000.00. In FY'00, proposals could be submitted up to a maximum of $30,000.00. In FY'00, 964 announcement letters were mailed to various industries throughout the state. As a result of these announcement letters and the advertisements published in the regional newspapers, the Office of Safety issues over 312 RFR's annually. Of the 312 RFR's issued, the DIA received 66 requests for funding (proposals). Of these, approximately 87% receive funding.

A uniform criteria to competitively evaluate all proposals received is developed by a Proposal Selection Committee, appointed by the Commissioner. The Committee recommends a list of qualified applicants for funding. Upon approval of this list by the Commissioner, contracts are awarded. As a result of this money, the Office of Safety was able to fund a total of 43 grants in FY'00 that resulted in the training of 25,018 employees throughout the Commonwealth. Over 98% of the participants rated the program they attended as "excellent" or "good."

## Frank S. Janas Training Center

At the grand opening of the new Lawrence Regional Office in October 2000, the DIA dedicated a new safety training center in memory of the late Frank Janas. Mr. Janas was a beloved DIA employee who worked in the Office of Insurance for seven years. The training center will be a valuable tool for both private employers and government agencies that would like to conduct safety-related training or seminars. The conference training center holds 90 auditorium style seats, has valuable conference amenities (wide-screen TV/VCR, Apollo projector, podium, computer hookups,etc.), and is handicap accessible.

**Frank Janas Training Center Contact:**
Thomas Nee, Director of Training
Department of Industrial Accidents
160 Winthrop Avenue
Lawrence, MA 01840
(978) 683-6420 ext. 138
(978) 683-3137 (fax)
email: thomasn@dia.state.ma.us

# OFFICE OF INSURANCE

The Office of Insurance issues self insurance licenses, monitors all self insured employers, maintains the insurer register, and monitors insurer complaints.

## Self Insurance

A license to self insure is available for qualified employers with at least 300 employees and $750,000 in annual standard premium.[27] To be self insured, employers must have enough capital to cover the expenses associated with self insurance. However, many smaller and medium sized companies have also been approved to self insure. The Office of Insurance evaluates employers every year to determine their eligibility and to establish new bond amounts.

For an employer to qualify to become self insured, it must post a surety bond of at least $100,000 to cover any losses that may occur.[28] The amount varies for every company depending on their previous reported losses and predicted future losses. The average bond is usually over $1 million and depends on many factors including loss experience, the financial state of the company, the hazard of the occupation, the number of years as a self insured, and the attaching point for re-insurance.

Employers who are self insured must purchase reinsurance of at least $500,000. The per case deductible of the re-insurance varies from $100,000, a relatively modest amount, to much higher amounts. Smaller self insured companies may also purchase aggregate excess insurance to cover multiple claims that exceed a set amount. Many self insured employers engage the services of a law firm or a third party administrator (TPA) to handle claims administration.

In FY'00, five new licenses were issued to bring the total number of "parent-licensed" companies to 173, covering a total of 437 subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. This amounts to approximately $221 million in equivalent premium dollars.

Four semi-autonomous public employers are also licensed to self insure including the Massachusetts Bay Transportation Authority (MBTA), the Massachusetts Turnpike Authority (MTA), the Massachusetts Port Authority, and the Massachusetts Water Resource Authority (MWRA).[29]

[27] C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers. These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover for all incurred losses.

[28] M.G.L. 452 C.M.R. 5:00.

[29] The Commonwealth of Massachusetts does not fall under the category of self insurance, although its situation is analogous to self insured employers. It is not required to have a license to self insure because of its special status as a public employer and it therefore funds workers' compensation claims directly from the treasury as a budgetary expense. The agency responsible for claims management, the Public Employee Retirement Administration, has similar responsibilities to an insurer, however, the state does not pay insurance premiums or post a bond for its liabilities (M.G.L. c.152, §25B).

## Insurance Unit

The Insurance Unit maintains a record of the workers' compensation insurer for every employer in the state. This record, known as the insurer register, dates back to the 1920's and facilitates the filing and investigation of claims after many years.

The insurance register had a record keeping system, which consisted of information manually recorded on 3x5 notecards, a time consuming and inefficient method for storing files and researching insurers. Every time an employer made a policy change, the insurer sent in a form and the notecard and the file was changed.

Through legislative action, the Workers' Compensation Rating and Inspection Bureau (WCRIBM) became the official repository of insurance policy coverage in 1991. The DIA was provided with computer access to this database, which includes policy information for the eight most current years. The remainder of policy information must be researched through the files at the DIA, now stored on microfilm. In FY'00, an estimated 4,700 inquiries were made to the Insurance Register.

The Insurance Unit is also responsible for handling insurance complaints. Complaints are often registered by telephone and the unit will provide the party with the necessary information to handle the case.

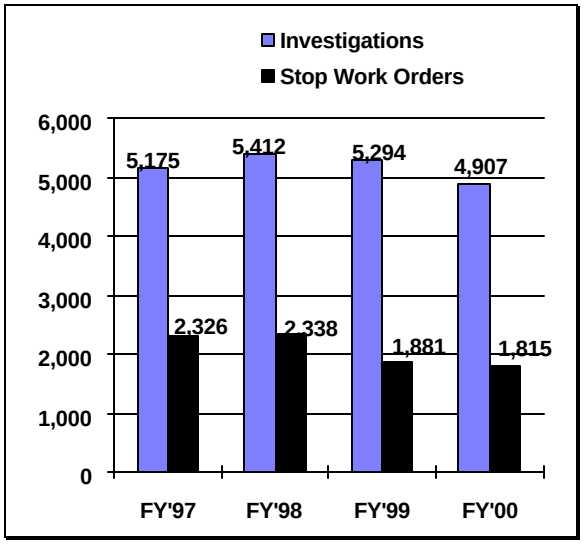
# OFFICE OF INVESTIGATIONS

In Massachusetts, employers are required to provide for payment of workers' compensation benefits. They may do so through the purchase of insurance, membership in a self insurance group, or licensing as a self insurer (M.G.L. c.152, §25A). The Office of Investigations of the Division of Industrial Accidents is charged with enforcing this mandate by investigating employers and imposing penalties for violations established by the legislature at M.G.L. c.152, §25C.

The Office has access to the Workers' Compensation Rating and Inspection Bureau (WCRIBM) database on all policies written by commercial carriers in the state. From this database, it can be determined which employers have canceled or not renewed their commercial insurance policies. Any employer appearing on this database is investigated for insurance coverage or alternative forms of financing (self-insurance, self-insurance group, reciprocal exchange). The WCRIBM database documents only those employers that currently have or previously had a commercial insurance policy. Therefore, this provides only one specific method of identifying uninsured employers in the state. Also, calls and letters are received from the general public, providing tips and suggestions of companies, which may be lacking appropriate insurance. Furthermore, license and permit audits often uncover fraudulent employers who fail to provide adequate coverage.

**Stop Work Orders** - The Office of Investigations, as required by the statute, will issue a "Stop Work Order" to any business with one or more full or part time employees that fail to provide proof of workers' compensation coverage upon demand. Such an order requires that all business operations cease and become effective immediately upon service. However, an employer may appeal the stop work order and remain open. In FY'00, 1,815 stop work orders were issued as a result of 4,907 investigations conducted. Of the 1,815 stop work orders issued, 1,807 (99%) were issued to "small" companies (1-10 employees), 8 were issued to "medium" companies (11-75 employees) and none were issued to "large" companies (76+ employees).

***Figure 19: MA SWO's & Investigations***

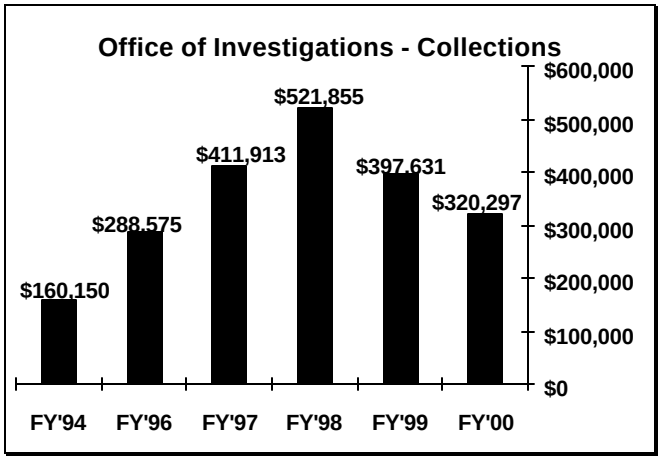



**Source**: Office of Investigations

**Fines and Penalties -** Fines resulting from a stop work order begin at $100.00 per day, starting the day the stop work order is issued, and continuing until proof of coverage to the DIA is obtained. An employer who believes the issuance of the stop work order was unwarranted has ten days to file an appeal. A hearing must take place within 14 days, during which time the stop work order will not be in effect. The stop work order and penalty will be rescinded if the employer can prove it had workers' compensation insurance during the disputed time. If at the conclusion of the hearing the Division finds the employer had not obtained adequate insurance coverage, the employer must pay a fine of $250.00 a day. This fine begins accruing from the original issuance of the stop work order, continuing until insurance is obtained (M.G.L. c.152, §25C). Any employee affected by a stop work order must be paid for the first ten days lost, and that period shall be considered "time worked."

In addition to established fines, an employer lacking insurance coverage may be subject to punishment by a fine not to exceed $1,500, or by imprisonment for up to one year, or both. If the employer continues to fail to provide insurance, additional fines and imprisonment may be imposed. The Commissioner or designee can file criminal complaints against employers (including the president and treasurer of a corporation personally) that violate any aspect of Section 25C. The amount collected in FY'00 was $320,297.

***Figure 20: Office of Investigations - Collections***




**Source**: Office of Investigations

**Licenses and Permits -** The statute requires that local or state licensing boards obtain proof of insurance prior to issuing or renewing a license or permit (i.e. building permits, liquor licenses).

**Public Contracts -** Section 25C states that neither the Commonwealth nor any of its political subdivisions should enter into any contract for public work if a particular business fails to comply with any of the insurance requirements of Chapter 152. Companies involved in any local, state or other public sector funded projects can be barred from all public funded projects for a three year period for failure to carry workers' compensation insurance.

**Losing a Competitive Bid -** Any business that loses a competitive bid for a contract may bring an action for damages against another business that is awarded the contract, because of cost advantages achieved by not securing workers' compensation insurance or deliberate misclassification of employees. If a violation is established, the person applying the suit shall recover, as liquidated damages, 10% of the total amount bid of the contract, or $15,000, whichever is less (M.G.L. c.152, §25C(9)).

# WORKERS' COMPENSATION TRUST FUND

Section 65 of the Workers' Compensation Act establishes a trust fund in the state treasury to make payments to injured employees whose employers did not obtain insurance, and to reimburse insurers for certain payments under sections 26, 34B, 35C, 37, 37A, and 30H. The DIA has established a department known as the Trust Fund to process requests for benefits, administer claims, and respond to claims filed before the Division of Dispute Resolution. In FY'00, the Trust Fund staff worked in conjunction with the General Counsel's Office to administer the fund.[30]

## Uninsured Employers

Section 65 of the Workers' Compensation Act directs the Trust Fund to pay benefits resulting from approved claims against Massachusetts' employers who are uninsured in violation of the law. The Trust Fund must either accept the claim or proceed to dispute resolution over the matter. Every claim against the fund under this provision must be accompanied by a written certification from the DIA's Office of Insurance, stating that the employer was not covered by a workers' compensation insurance policy on the date of the alleged injury, according to the Division's records.[31] In FY'00, $3,390,180 was paid to uninsured claimants, 160 claims were filed, and 96 claims for benefits were paid.

## Second Injury Fund Claims (Sections 37, 37A, and 26)

In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund to offset any financial disincentives associated with the employment of injured workers.

Section 37 requires insurers to pay benefits at the current rate of compensation to all claimants, whether or not their injury was exacerbated by a prior injury. When the injury is determined to be a "second injury[32]," insurers become eligible to receive reimbursement from the DIA's trust fund for up to 75% of compensation paid after the first 104 weeks of payment. Employers are entitled to an adjustment to their experience modification factors as a result of these reimbursements.

Section 37A was enacted to encourage the employment of servicemen returning from World War II. The Legislature created a fund to reimburse insurers for benefits paid for an injury aggravated or prolonged by a military injury. Insurers are entitled to reimbursement for up to fifty percent of the payments for the first 104 weeks of compensation and up to one hundred percent for any amount thereafter.

[30] Section 65 of the act specifies that the reasonable and necessary costs of administering and representing the Workers' Compensation Trust Fund may be paid out, without appropriation, of the Trust Fund.

[31] 452 C.M.R. 3.00

[32] An employee is considered to suffer a second injury when an on the job accident or illness occurs that exacerbates a pre-existing disability. How the preexisting condition was incurred is immaterial; the impairment may derive from any previous accident, disease, or congenital condition. The disability, however, must be "substantially greater" due to the combined effects of the preexisting impairment and the subsequent injury than the disability as a result of the subsequent injury by itself.

Section 26 provides for the direct payment of benefits to workers injured by the activities of fellow workers, where those activities are traceable solely and directly to a physical or mental condition, resulting from the service of that fellow employee in the armed forces. (A negligible number of these claims have been filed.)

At the close of fiscal year 2000, 321 §37 claims were paid and 388 were settled. The total amount paid in settlements in FY'00 was $23,593,801.

## Vocational Rehabilitation (Section 30H)

Section 30H provides that if an insurer and an employee fail to agree on a vocational rehabilitation program, the Office of Education and Vocational Rehabilitation (OEVR) must determine if vocational rehabilitation is necessary and feasible to return the employee to suitable employment. If OEVR determines that vocational rehabilitation is necessary and feasible, it will develop a rehabilitation program for the employee for a maximum of 104 weeks. If the insurer refuses to provide the program to the employee, the cost of the program will be paid out of the Section 65 trust funds. If upon completion of the program OEVR determines that the program was successful, it will assess the insurer no less than twice the cost incurred by the office, with that assessment paid into the Trust Fund. In FY'00, $8,278 was paid for rehabilitation services and the DIA collected $8,846 from insurers. During FY'00, 4 claims for benefits were filed and 4 claims for benefits were paid out.[33]

## Latency Claims (Section 35C)

Section 35C states that when there is at least a five year difference between the date of injury and the date of benefit eligibility (for section's 31, 34, 35A or 35), benefits' paid will be based upon levels in effect on the date of eligibility. This same date of eligibility rather than the date of injury is also used to compute supplemental benefits known as COLA (Cost of Living Adjustments) for employees subject to this section. In FY'00, approximately $798,983 was paid as latency claims.[34]

## Cost of Living Adjustments (Section 34B)

Section 34B provides supplemental benefits for persons receiving death benefits under section 31 and permanent and total incapacity benefits under section 34A, whose date of personal injury was at least 24 months prior to the review date. The supplemental benefit is the difference between the claimant's current benefits and his/her benefit after an adjustment for the change in the statewide average weekly wage between the review date and the date of injury.Insurers pay the supplemental benefit concurrently with the base benefit. They are then entitled to quarterly reimbursements for the supplemental benefits paid on all claims with dates of injury occurring prior to October 1, 1986. For injury dates after October 1, 1986, insurers will be reimbursed for any increase that exceeds 5%. COLA payments for FY'00 totaled $1,792,993 for the Public Trust Fund and $12,486,248 for the Private Fund.

[33] The FY'99 Annual Report contained erroneous information regarding Trust Fund benefits filed and paid out for vocational rehabilitation services.

# OFFICE OF HEALTH CARE SERVICES BOARD

The DIA is charged with ensuring that adequate and necessary health care services are provided to the state's injured workers. Specifically, the statute directs the Commissioner to monitor health care providers for appropriateness of care, necessary and effective treatment, the proper costs of services, and the quality of treatment. The statute directs the Commissioner to appoint medical consultants to the Medical Consulting Consortium and members to the Health Care Services Board (see Appendix H).

## Health Care Services Board

The DIA's Health Care Services Board (HCSB) is a voluntary committee of health care providers, as well as employer and employee representatives. The HCSB is charged with reviewing and investigating complaints against providers, developing appointment criteria for the impartial physicians roster, and developing written treatment guidelines used for utilization review.

**Complaints Against Providers** - The HCSB is required to accept and investigate complaints from employees, employers and insurers regarding the provision of health care services. Such complaints include provider's discrimination against compensation claimants, over-utilization of procedures, unnecessary surgery or other procedures, and inappropriate treatment of workers' compensation patients. Upon a finding of a pattern of abuse by a particular provider, HCSB is required to refer its findings to the appropriate board of registration.

**IME Roster Criteria** - The HCSB is also required to develop eligibility criteria to select and maintain a roster of qualified impartial physicians to conduct medical examinations pursuant to M.G.L. c.152, §8(4) and §11A. The HCSB issues criteria for the selection of eligible roster participants. According to the criteria, physicians must be willing to prepare reports promptly and timely; submit reports for depositions; submit reports of new evidence; submit to the established fee schedule; and sign a conflicts of interest statement and disclosure of interest statement. The requirements of the §8(4) roster and the §11(A) roster differ pursuant to M.G.L. c.152.

**Treatment Guidelines** - Under section 13 of Chapter 152, the Commissioner is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, including appropriate parameters for treating injured workers. An advisory group was appointed to develop these treatment guidelines.

The HCSB has published twenty-five treatment guidelines covering many conditions common to workers' compensation patients. The HCSB is required to conduct an annual review of the guidelines and update them based on the experience of the year.

[34] Legal expenditures totaled $145,943.

## Utilization Review

According to the Division's regulations (452 C.M.R. 6.00), utilization review is a system for reviewing the "appropriate and efficient allocation of health care services" to determine whether those services should be paid or provided by an insurer. The regulations specify that all utilization review programs must be approved by the DIA. Insurers, self insurers and self insurance groups must either develop their own utilization review programs for DIA approval or contract with approved agents who can provide the required utilization review services for them.

The regulations require that utilization review be performed on all medical claims using the DIA's treatment guidelines and criteria. UR agents must review claims submitted by workers' compensation claimants for compliance with the guidelines. Review may either be prospective (examining treatment before it is provided), concurrent (review in the course of treatment), or retrospective (review after the treatment was provided).

When coverage for a treatment plan is denied by an agent, it must be communicated to the treating physician and the injured employee. Either the injured employee or the treating practitioner may appeal the denial. Appeals of prospective or concurrent treatment may be made by telephone to the UR agent, with the opportunity for review by a practitioner on an expedited basis. The appeal must be resolved within two business days. Appeals for retrospective treatment must be settled within 20 business days. Examination of any utilization review appeal can be made by filing a claim with the DIA's Division of Dispute Resolution.

## Medical Utilization Trending and Tracking System

The Commissioner is required to implement within the Division a quality control system regarding delivery of health care services to injured workers. The statute states that the DIA should "monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment."[35]

According to the regulations promulgated in furtherance of this directive (452 CMR 6.07), the DIA intends to monitor the quality of care for injured employees using outcome measures, medical record audits, analysis of employee health status and patient satisfaction measurements. Should a provider's pattern of care for a particular condition be found to be frequently outside the parameters of a particular treatment guideline, the provider will be informed of the aberration with instructions on the means to correct it. Should the provider remain statistically outside the guideline, the matter will be referred to the Commissioner for such further action as he may deem appropriate.

In FY'93, the Department began the process of developing an evidence-based medical utilization data tracking and trending system intended to satisfy the Department's statutory obligation to monitor the medical services, trends in costs, and patterns of treatment of Massachusetts injured workers. The system, called "MUTTS", for Medical

[35] M.G.L. c.152, §13.

Utilization Tracking and Trending System, would utilize expert predictive data processing technology to monitor the trends in services, costs and patterns of medical treatment provided to the Commonwealth's injured workers. This data will be used to not only monitor the over or under-use of medical services, but also create "best practice" standards from which additional treatment guidelines could be derived and improvements in patient care could emanate.

## DIA's 5-year contract for MUTTS development

**Year 1** (FY'97) of the contract emphasized project design. A survey was developed to assess the insurance industry's capability of submitting medical claims data to the DIA. Specifically, the survey's objective was to inform the DIA on how the industry processed their workers' compensation medical claims data, so the contractor would be able to develop a workable system to retrieve this data. During this year, the survey was completed and the contractor began creating the database to import insurance industry claims data.

**Year 2** (FY'98) of the project, the contractor began the process of "coding" the system, so collected data from insurance companies could be processed in a uniform manner.

**Year 3** (FY'99) of the project, MUTTS was pilot tested using actual Massachusetts' data provided by one major insurer and three large Third Party Administrators representing several insurers. The data was successfully run through the system and its design validated.

**Years 4 and 5** (FY'00-'01) of the project were scheduled to be operational years, with insurers beginning to submit the required medical claims data to the contractor. However, various concerns, heightened by Executive Order No. 412, prompted the Department to enlist the Attorney General's Office in a general review of the MUTTS program instead. Upon completion of the Attorney General's review, the Department will proceed with MUTTS development and implementation.

As explained by Commissioner James J. Campbell at the June 9, 1999 Joint Committee on Commerce & Labor hearing, MUTTS is the final medical initiative of the workers' compensation reform of 1991. In part, the workers' compensation statute states that the DIA should "monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment" (M.G.L. c.152, §13).

***Table 20: CHER's Project Phases & Completion Status for MUTTS***

| FISCAL YEAR | PHASE | DEFINITION | STATUS |
|---|---|---|---|
| 1997 | 1 | Project Design/Insurance Company Survey | Completed |
| 1998 | 2 | Obtain Data/Produce Reports/Coding System | Completed |
| 1999 | 3 | Full Set of Pilot Data*/Produce Reports | Completed |
| 2000 | 4 | Operational Year: Requires Data from Insurance Companies | Pending |
| **2001** | **5** | **Operational Year: Requires Data from Insurance Companies** | **Current** |

*Pilot data from: AON; Buckler, Irvin & Graf; Managed Benefit Services; and Travelers Insurance.

# THE REGIONAL OFFICES

The Division of Industrial Accidents has offices in Boston, Lawrence, Worcester, Fall River, and Springfield. Headquarters are located in Boston, and all DIA case records are stored in Boston.

The Senior Judge and the managers of the conciliation and vocational rehabilitation units are located in Boston, but each has managerial responsibility for the operations of their respective Divisions at the regional offices.

Each regional office has a regional manager, a staff of conciliators, stenographers, vocational rehabilitation counselors, disability managers, administrative secretaries, clerks, and data processing operators. In addition, administrative judges make a particular office the base of their operations, with an assigned administrative secretary.

## Administration and Management of the Offices

Each regional manager is responsible for the administration of his or her regional office. The offices are equipped with conference rooms and hearings rooms in which conciliations, conferences, hearings and other meetings are held. A principle clerk and a data processing operator manage the scheduling of these proceedings and the assignment of meeting rooms through the Diameter case scheduling system.

Cases are assigned to administrative judges by the Diameter system in coordination with the Senior Judge. Conciliators are assigned cases according to availability on the day of the meeting, and report to the conciliation manager located at the Boston office. Likewise, stenographers are assigned when needed, but report to the stenographer manager at the Boston office. The vocational rehabilitation personnel report directly to the OEVR manager in the Boston office, and take assignments as delegated from Boston.

When an employee or insurer files a workers' compensation claim or complaint with the DIA, the case is assigned to the office geographically closest to the home of the claimant. Assignments are based on zip codes, with each regional office accounting for a fixed set of zip codes.

Each regional office occupies space rented from a private realtor. The manager is responsible for working with building management to ensure the building is accessible and that the terms of the lease are met. Moreover, each regional manager is responsible for maintenance of utilities, including the payment of telephone, electricity, and other monthly services. Therefore, the costs of operating each office is managed by each regional manager.

## Resources of the Offices

Each of the regional offices has moved to expanded and enhanced office space within the last six years.

Court rooms have been updated and modernized according to the needs of each regional office, including handicap accessibility and security systems. Moreover, each regional office is equipped with video equipment to assist with the presentation of court room evidence.

Each office has been provided with personal computers networked to the Boston office and with a CD ROM for access to software on the MA General Laws, MA court reporters, and DIA reports.

**The following are addresses for the regional offices:**

**Fall River**
30 Third Street
Fall River, MA 02722
(508) 676-3406
**Henry Mastey, Manager**

**Lawrence**
160 Winthrop Avenue
Lawrence, MA 01840
(978) 683-6420
**Louis Connolly, Manager**

**Springfield**
436 Dwight Street, Room 105
Springfield, MA 01103
(413) 784-1133
**Marc Joyce, Manager**

**Worcester**
8 Austin Street
Worcester, MA 01608
(508) 753-2072
**Jonathan Ruda, Manager**

# SECTION
# - 5 -
# *DIA FUNDING*

# DIA FUNDING

To ensure that the Division of Industrial Accidents has adequate funds, the Legislature required the employers of Massachusetts, both public and private, to pay assessments covering the expenses of operating the agency and for the payment of trust fund benefits. In addition to these assessments, the DIA also derives revenue from the collection of fees (for various filing costs) and fines (for violations of the act).

Each year, the DIA must determine an assessment rate that will yield revenues sufficient to pay the obligations of the workers' compensation trust funds and the operating costs of the DIA. This assessment rate, multiplied by the employer's standard premium, is the DIA assessment, and is paid as part of an employer's insurance premium.[36]

The assessment rate for private sector employers in FY'01 is 3.953% of standard premium. This is a 2% decrease from the FY'00 rate of 4.038%.

**The Trust Funds** - The DIA must make payments to uninsured, injured employees and employees denied vocational rehabilitation services by their insurers. In addition, it must reimburse insurers for benefits for second and latent injuries, injuries involving veterans, and for specified cost of living adjustments.[37]

These obligations are paid out of the trust funds.[38] One account is reserved for payments to private sector employers (the private trust fund); the other is for payments to public sector employers (the public trust fund).

**The Special Fund** - The DIA's operating expenses are paid from a Special Fund, funded entirely by assessments charged to private sector employers. Operating expenses must be appropriated by the legislature each year through the General Appropriations Act.

Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the DIA's operating budget as well as the Workers' Compensation Trust Fund budgets. With the affirmative vote of seven members, the Council may submit an alternative budget to the Director of Labor and Workforce Development.

[36] For employers that are self insured or are members of self insured groups, an "imputed" premium is determined, whereby the WCRB will estimate what their premium would have been had they obtained insurance in the traditional indemnity market. Some employers are entitled to "opt out" from paying a full assessment. By opting out, the employer agrees that it can not seek reimbursement for benefits paid under sections 34B, 35C, 37, 30H, 26, and 37A. Separate opt out assessment rates are determined each year.

[37] M.G.L. c.152, §65(2).

[38] Each year the DIA creates a budget for the private and public trust funds, collects assessments, and disburse funds as obligations arise, without appropriation from the legislature.

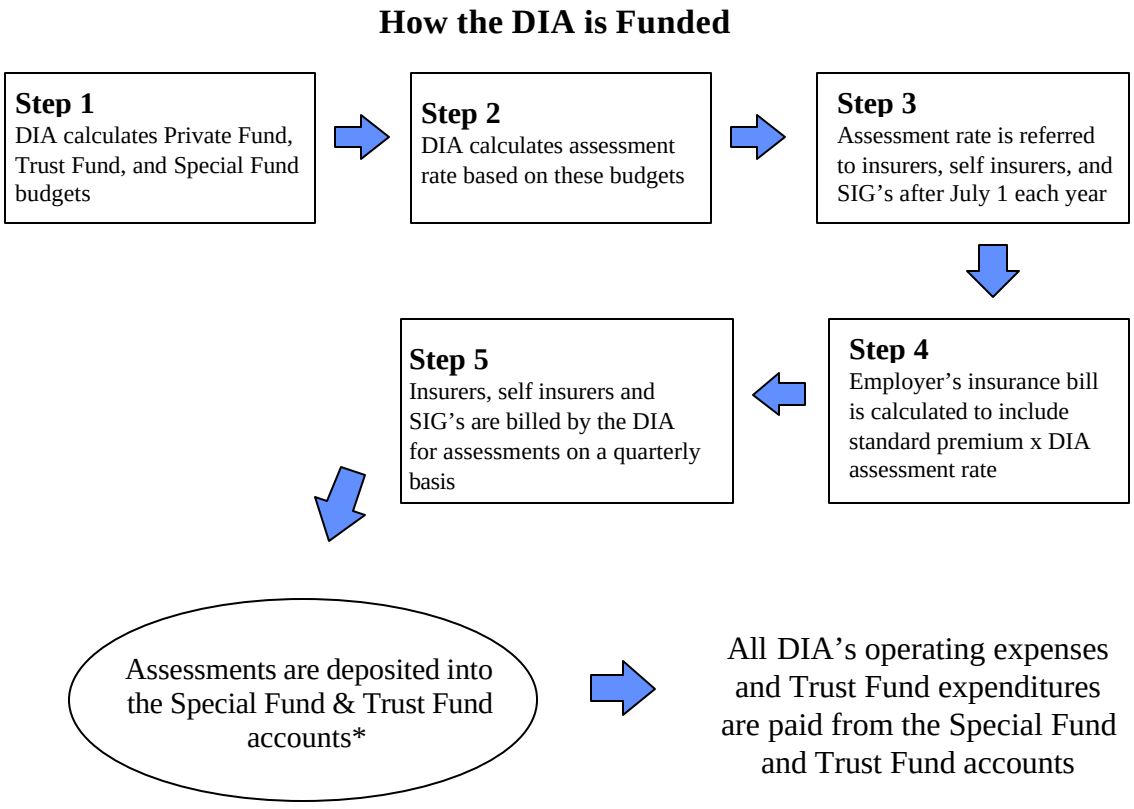
# The Funding Process

At the beginning of each fiscal year, the DIA estimates the amount of money needed to maintain its operations in the next fiscal year. This amount is refined by December, when it is submitted to the Governor's office for inclusion in the Governor's budget (House 1), and submitted for legislative action.

In May and June the DIA, along with the assistance of consulting actuaries, estimates future expenses and determines assessments necessary to fund the special fund and the trust fund. The budgets and the corresponding assessments must be submitted to the Director of Labor and Workforce Development by July 1st of each year.

By July, the Legislature appropriates the DIA's operating expenses. At that time, insurance carriers are notified of the assessment rates paid quarterly directly to the DIA. Collected assessments are deposited into the DIA's accounts, which are managed by the Commonwealth's Treasurer.

***Figure 21: DIA Funding Process***

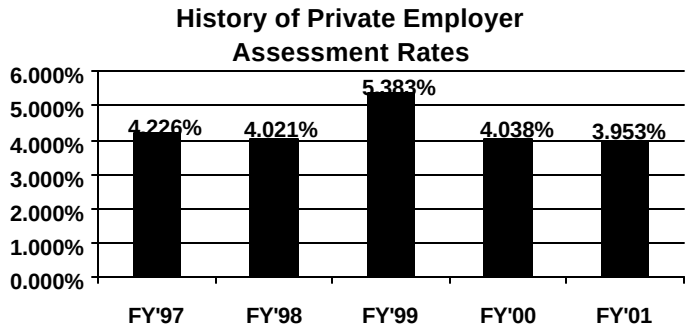



*Note: Maintained by the State Treasurer.

# PRIVATE EMPLOYER ASSESSMENTS

On August 3, 2000, Tillinghast released a revised analysis of the DIA FY'01 assessment rates as mandated under M.G.L. c.152, §65. Specifically, the report detailed the estimated amount required by the special fund and trust funds for FY'01, beginning July 1, 2000. Included in the report are the assessment rates to be applied to public and private employer insurance premiums. The private employer assessment rate has been calculated to be **3.953%** of standard premium, a decrease of 2% from last year (4.038%).

***Figure 22: History of Private Employer Assessment Rates***




The public employer assessment rate has been calculated to be **24.221%** of standard premium, an increase of 29% from last year's assessment (18.787%). This memorandum breaks down the process of the assessment rate calculation for private employers.

## OVERVIEW OF ASSESSMENT RATE CALCULATIONS

Tillinghast uses the following six steps in determining the assessment rates for both private and public employers:

1. Project the Fiscal Year 2001 Expenditures;
2. Project the Fiscal Year 2001 Income (excluding assessments);
3. Estimate Balance Adjustments;
4. Convert Above Items to Ratios by comparing them to the Assessment Base;
5. Calculate the Assessment Ratio by Subtracting the Projected Income and Balance Adjustment Ratios from the Projected Expenditure Ratio; and
6. Calculate the Assessment Rate by multiplying the Assessment Ratio by the Assessment Base Factor.

**1. FISCAL YEAR 2001 PROJECTED EXPENDITURES: $58.9M**

The first step in the assessment process is the calculation of the expected FY'01expenditures. Private employers are assessed for the sum of the Private Trust Fund budget and the Special Fund budgets.

| PRIVATE TRUST FUND BUDGET | Projected FY'01 Expenditures (6/21/00) |
|---|---|
| Section 37 (2nd Injuries) | $16,474,625 |
| Uninsured Employers | $ 3,375,000 |
| Section 30H (Rehabilitation) | $ 0 |
| Section 35C (Latency) | $ 840,000 |
| Section 34B (COLA's) | $14,552,376 |
| Defense of the Fund | $ 1,800,000 |
| ***Total:*** | **$37,042,001** |

| SPECIAL FUND BUDGET | Projected FY'01 Expenditures (6/21/00) |
|---|---|
| ***Total:*** | **$21,839,000** |

| PRIV. EMPLOY. EXPENDITURES | Projected FY'01 Expenditures (6/21/00) |
|---|---|
| ***Total:*** | **$58,881,001** |

**2. PROJECTED FISCAL YEAR 2001 INCOME: $6.8M**

Any income derived by the funds is used to offset assessments. An amount is projected for the collection of fees and fines for deposit in the Special Fund, reimbursements from uninsured employers for deposit in the Private Trust Fund, and an amount estimated for interest earned on the Private Fund and the Special Fund balances.

***FY'01 Fines and Fees (Special Fund)*** = $4,700,000
***FY'01 Income Due to Reimbursements*** = $1,000,000
***Estimated Investment Income (FY'00)*** = $1,073,345 (Private Fund: $656,266/Special Fund: $417,079)

**Total Projected FY'01 Income: $6,773,345**

**3. ADJUSTMENTS TO FUND BUDGETS: $14.8M**

According to M.G.L. c.152, §65(4)(c), the amount assessed employers for any fund must be reduced by a certain percentage of moneys held over from the previous year. Any amount greater than 35% of FY'99 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'01. The balances of both Special Fund and Private Trust Fund at the end of FY'00 will have a surplus exceeding 35% of FY'99 disbursements. Therefore, the assessment was calculated with a $6.7 million reduction to

the Special Fund Budget, and a $8.1 million reduction to the Private Trust Fund Budget ($14.8 million reduction).

| ***SPECIAL FUND:*** | **FY'00 Estimated Year End Balance** | **35% of FY'99 Expenditures** | **Amount of Reduction Required** |
|---|---|---|---|
| | $13,902,641 | $7,221,911 | $6,680,730 |

| ***PRIVATE TRUST FUND:*** | **FY'00 Estimated Year End Balance** | **35% of FY'99 Expenditures** | **Amount of Reduction Required** |
|---|---|---|---|
| | $21,875,526 | $13,718,765 | $8,156,760 |

**4. CONVERSION TO RATIO:**

Expenditures, income, and any balance adjustment must be converted to a ratio. This is calculated by dividing each of the first three steps by the assessment base, which represents losses paid during Calendar Year 1999. For the Private Fund, the assessment base is $631.6M.

| | | |
|---|---|---|
| ***Private Expenditure Ratio:*** | 9.321% | ($58.9 million/$631.6 million) |
| ***Projected Income Ratio:*** | 1.072% | ($ 6.8 million/$631.6 million) |
| ***Balance Adjustment Ratio:*** | 2.348% | ($14.8 million/$631.6 million) |

**5. CALCULATION OF THE ASSESSMENT RATIO: 5.901%**

After the projected expenditures, income and balance adjustments are converted to ratios, the last two items are subtracted from the expected expenditure ratio to calculate an assessment ratio.

| Projected expenditures - | Projected income - | Balance adjustment = | **Assessment Ratio** |
|---|---|---|---|
| 9.321% | 1.072% | 2.348% | **5.901%** |

**6. CALCULATION OF THE ASSESSMENT RATE: 3.953%**

Since the assessment ratio is relative to paid losses, the ratio must be converted into a rate that is relative to projected premiums. This is done by multiplying the assessment ratio by an assessment base factor, which represents a ratio of losses to premiums (based on information provided by the WCRIBM). The 2001 assessment base factor is .670.

| Assessment Ratio x | Assessment Base Factor = | **Assessment Rate** |
|---|---|---|
| 5.901% | .670 | **3.953%** |

# THE DIA OPERATING BUDGET

## Legislative Appropriations, Fiscal Year 2001

The Division of Industrial Accidents initially requested a budget of $18,400,868 for fiscal year 2001. In House 1, the Governor's recommendation for the DIA's budget was $17,878,036 ($522,832 less than the DIA's original request). The House of Representatives approved a budget of $18,044,865 and the Senate approved appropriations totaling $17,815,834. The final conference committee resolution appropriated $17,815,834.

***Table 21: Legislative Appropriations, Fiscal Year 2001***

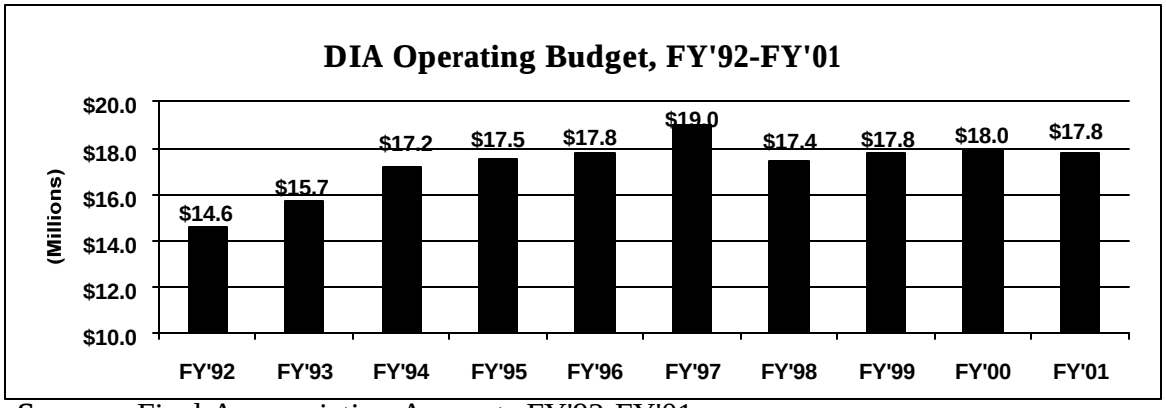
| | |
|---|---|
| **DIA Request** | **$18,400,868** |
| **Governor's Recommendation** | **$17,878,036** |
| **Full House** | **$18,044,865** |
| **Full Senate** | **$17,815,834** |
| **Conference Committee** | **$17,815,834** |

**Source:** Legislative Budget Figures

## General Appropriations Act

On July 28, 2000, Governor Cellucci signed the General Appropriations Act, giving the DIA a **$17,815,834** operating budget for fiscal year 2001. This year's appropriation is $256,180 less than last year's appropriation amount of $18,072,014. The appropriation was made to a single account.

Provisions in the DIA's appropriation include that $800,000 be expended for occupational safety grants and a judge be assigned to hear cases in Berkshire County not less than once a month. Furthermore, the allocation allows for the release of sufficient funds from the special fund reserve to pay for expenses associated with converting the agency's computer system from Unify to Oracle. The special fund reserve may only be released by an affirmative vote of seven members of the Advisory Council.



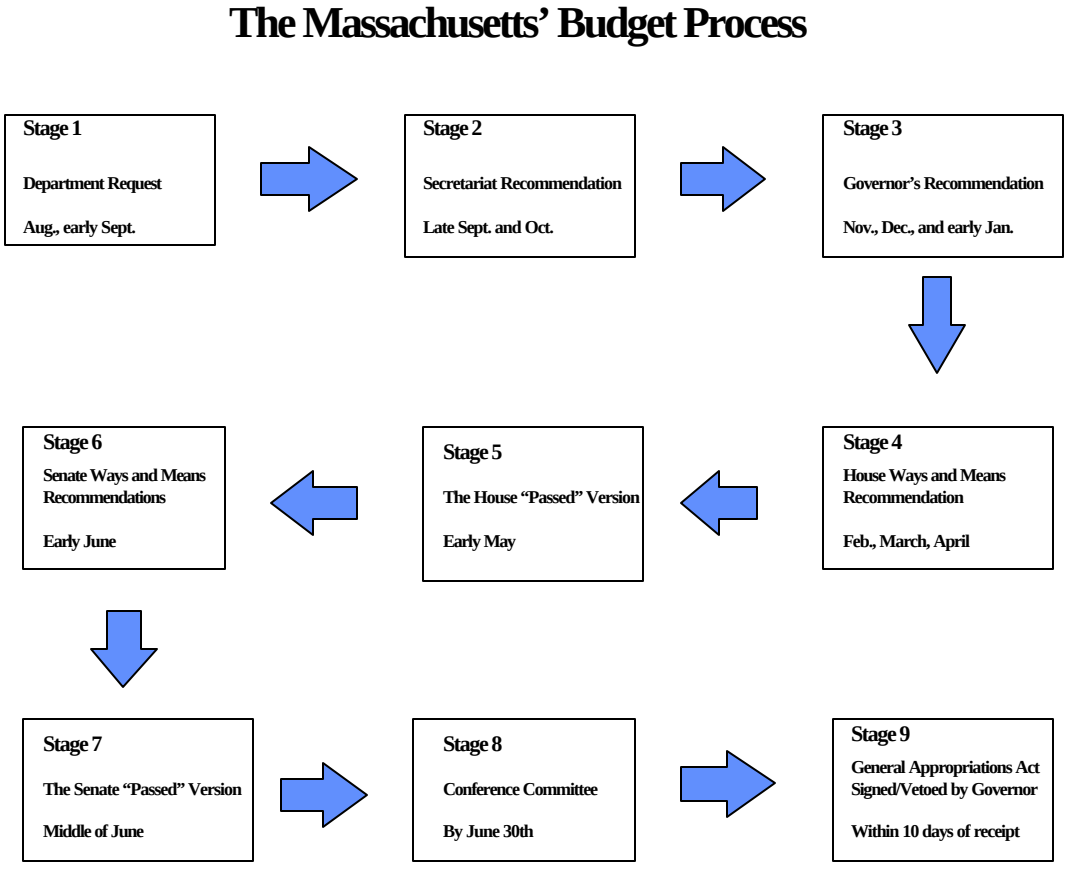

**Source:** Final Appropriation Amounts FY'92-FY'01.

# The Budget Process

The operating budget of the DIA must be appropriated by the Legislature even though employer assessments fund the agency. The Division, therefore, must submit to the budget process in the same manner as most other government agencies. It is helpful to view this process in nine distinct phases.[39]

The following is a brief description of the process:

***Figure 23: The Massachusetts' Budget Process***




[39] Making and Managing the Budget in the Commonwealth of Massachusetts, Donahue Institute for Government Services, University of Massachusetts.

**Stage 1: Department Request**

**Time Frame:** August and early September

Each department submits a budget for the next fiscal year and a spending plan for the current fiscal year to the Budget Bureau.

**Stage 2: Secretariat Recommendation**

**Time Frame:** Late September and October

The Secretariats analyze each department's requests and meet with department heads to further review respective budgets. Each Secretary will then make their recommendations for the budget.

**Stage 3: Governor's Recommendation (House 1)**

**Time Frame:** November, December, and 1st weeks of January

The Governor's recommendation must be the first bill submitted to the House of Representatives each calendar year. On the fourth Wednesday in January, copies of House 1 are distributed to members of the House and Senate, the Executive Secretaries and department heads, the media, and to any other interested parties. The Governor's recommended budget must be balanced and include all revenue accounts and all expenditure accounts.

**Stage 4: House Ways and Means Committee Recommendations**

**Time Frame:** February, March, and April

House 1 is referred to the House Ways and Means Committee where each line item is analyzed. Public hearings are held in which testimony is taken from the Governor's staff, executive secretariats, departments, and any other interested parties. In April, a new version of the budget replaces House 1 and is traditionally given the label of House 5600.

**Stage 5: The House "Passed" Version**

**Time Frame:** Early May

The members of the House of Representatives take over by subjecting each line item in the budget to debate and amendments. The full House votes to pass a new version of the budget, traditionally known as House 5700.

**Stage 6: Senate Ways and Means Committee Recommendations**

**Time Frame:** Early June

House 5700 is referred to the Senate Ways and Means Committee where hearings and testimony are held. Typically by early June, a recommendation will be published and given to members of the Senate and interested parties. The Chairperson and members of the Committee will hold a press conference to address concerns with this new version of the budget.

**Stage 7: The Senate "Passed" Version**

**Time Frame:** Middle of June

The full Senate reviews each line item and section and subjects them to debate and amendment. Members of the Senate will then vote to pass the new, updated budget.

**Stage 8: Conference Committee**

**Time Frame:** By June 30th

A Conference Committee is created in an effort to resolve differences between the House passed version of the budget and the Senate version. Members of this committee include the chair of both Ways and Means Committees and ranking minority party members from both committees. The only budget information the Conference Committee can analyze is what survived from the House and Senate debates. Compromises are made on each line item by selecting either the budget amount from the House version, the Senate version, or a number in between the two versions. Finally, a new draft is created that both the House and Senate must ratify. If one branch does not ratify the budget, it is sent back to Conference Committee for more work. Once the budget is ratified, it is signed by the Speaker of the House and the President of the Senate. (An interim budget can be enacted by the legislature if the budget is late to allow the government to continue spending while the appropriation act is being finished.)

**Stage 9: General Appropriations Act**

**Time Frame:** Within 10 days of receipt

The Governor has 10 calendar days to decide his position on the budget. During this period, the Governor may both sign the budget and approve as complete; veto selected line items (reduce to zero) but approve and sign the rest; or partially veto (reduce to a lower number) selected line items and approve and sign the rest. The Legislature has the power to override a Governor's veto by a 2/3 vote in both chambers.

# SECTION
# - 6 -
# *INSURANCE COVERAGE*

# MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.[40] Coverage may consist of purchasing a commercial insurance policy, membership in a self-insurance group, participation in a reciprocal insurance exchange,[41] or maintaining a license as a self-insured employer.

All Commonwealth of Massachusetts employees are covered under the Workers' Compensation Act, with claims paid directly from the General Fund. The Executive Office of Administration & Finance, Human Resources Division administers workers' compensation claims, with individual agencies paying a yearly "charge back" based on losses paid in the prior year. This charge back comes directly from each agency's operating budget.

When enacted in 1911, the Workers' Compensation Act was elective for counties, cities, towns, and school districts. The vast majority of municipal employees, however, are covered, with only a few communities having never adopted coverage for certain employee groups. Municipalities attain insurance coverage in a manner identical to private employers that is through commercial insurance, self-insurance, or membership in a self-insurance group. [42]

The Office of Investigations at the Division of Industrial Accidents (DIA) monitors employers in the state to ensure no employer operates without insurance. The office may issue fines and close any business operating without coverage.[43] If an employee is injured while working for a company without coverage, a claim may be filed with the DIA's trust fund.[44]

[40] This mandate includes sole proprietors that are incorporated, domestics and seasonal workers that average over 16 hours of work a week, and family businesses employing family members. There are certain categories of workers for whom insurance is not required. Seamen, some professional athletes, and unincorporated sole proprietors are exempt.

[41] A reciprocal exchange is a group of employers from diverse industries who pool their funds to insure themselves. An exchange is not self insurance or a self insurance group, but a way to provide commercial insurance to small and medium sized companies without resorting to the residual market.

[42] For more information of the coverage of public employees see Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, 1989.

[43] See section covering Office of Investigations.

[44] See section covering Trust Fund.

# COMMERCIAL INSURANCE

Purchasing a commercial insurance policy is the most common method of complying with the workers' compensation mandate. These policies are governed by the provisions of M.G.L. c.152, and are regulated by the Division of Insurance (DOI). The Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) has delegated authority to determine standard policy terms, classifications, and manual rates, in addition to maintaining statistics on behalf of the Commissioner of Insurance.

While commercial insurance policies are available that provide for varying degrees of risk retention (such as small and large deductibles), the most common type is first dollar coverage, whereby all losses are paid from the first dollar incurred for medical care and indemnity payments. A variety of pricing mechanisms are also available (including retrospective rating and dividend plans), with the most common being guaranteed cost. In exchange for payment of an annual premium based on rates approved each year by the Commissioner of Insurance, an employer is guaranteed that work related injuries and illnesses will be paid in full by the insurer.

The WCRIBM's Massachusetts Workers' Compensation and Employers Liability Insurance Manual sets forth the methods to determine the classification of insureds as well as terms of policies, premium calculation, credits and deductibles.

## The Insurance Market

The commercial insurance market is the primary source of funding for workers' compensation benefits in Massachusetts. A healthy insurance market, therefore, is essential to the welfare of both employees and employers.

Commercial insurance carriers are regulated by the DOI, which provides licensing, monitors solvency, determines rates, approves the terms of policies, and adjudicates unfair claims handling practices.

In FY'00, the DOI issued 8 new licenses to carriers to write workers' compensation insurance in Massachusetts. Drawn by favorable market conditions marked by decreased loss costs, carriers from around the nation have entered the state in search of profitable underwriting opportunities. This has intensified competition amongst carriers for market share, fueling a record number of downward deviations. Employers have been the beneficiaries of competition, experiencing dramatic reductions to their insurance costs as a result of a large decrease in manual rates, compounded with double digit reductions provided by individual carriers.

**Insurance Rates** - In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.[45] Insurance rates are proposed by the Workers' Compensation Rating and Inspection Bureau of Massachusetts(WCRIBM) on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRIBM submits to the Commissioner a classification of risks and premiums, referred to as the rate filing, which is reviewed by the State Rating Bureau. By law, a rate filing must be submitted at least every two years, and no classifications or premiums may take effect until approved by the Commissioner.[46]

According to the Workers' Compensation Act, the Commissioner of insurance must conduct a hearing within 60 days of receiving the rate filing, to determine whether the classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that "they fall within a range of reasonableness."[47]

On August 24, 1999, Insurance Commissioner Linda Ruthardt ordered a 20.3% reduction in average workers' compensation rates.[48] This marks a continuing trend of rate decreases since 1994. Assuming a manual rate of $100 in 1987, rates have since decreased by 15.4%. The issued rate decision continued through Fiscal Year 2000.

**Table 22: Impact of Rate Changes since 1987**

| YEAR | Percent Change from Previous Year's Rate | Assuming a Manual Rate of $100 in 1987 |
|---|---|---|
| 1987 | No Change | $110.00 |
| 1988 | + 19.9% | $119.90 |
| 1989 | + 14.2% | $136.93 |
| 1990 | + 26.2% | $172.81 |
| 1991 | + 11.3% | $192.34 |
| 1992 | No Change | $192.34 |
| 1993 | + 6.24% | $204.34 |
| 1994 | - 10.2% | $183.50 |
| 1995 | - 16.5% | $153.22 |
| 1996 | - 12.2% | $134.53 |
| 1997 | No Change | $134.53 |
| 1998 | - 21.1% | $106.15 |
| 1999 | -20.3% | $ 84.60 |
| **2000** | **No Change** | **$84.60** |

**Source**: Division of Insurance WC Rate Decisions

[45] In the United States, workers' compensation insurance rates are regulated one of three ways: through administered pricing, competitive rating, or a monopolistic state fund. Administered pricing involves strict regulation of rates by the state. Competitive rating allows carriers to set rates individually, usually based on market-wide losses developed by a rating organization and approved by the state. Monopolistic state funds require that workers' compensation insurance be purchased exclusively through a program run by the state. Some states have competitive state funds that allow employers to purchase insurance from either a private carrier or the state.

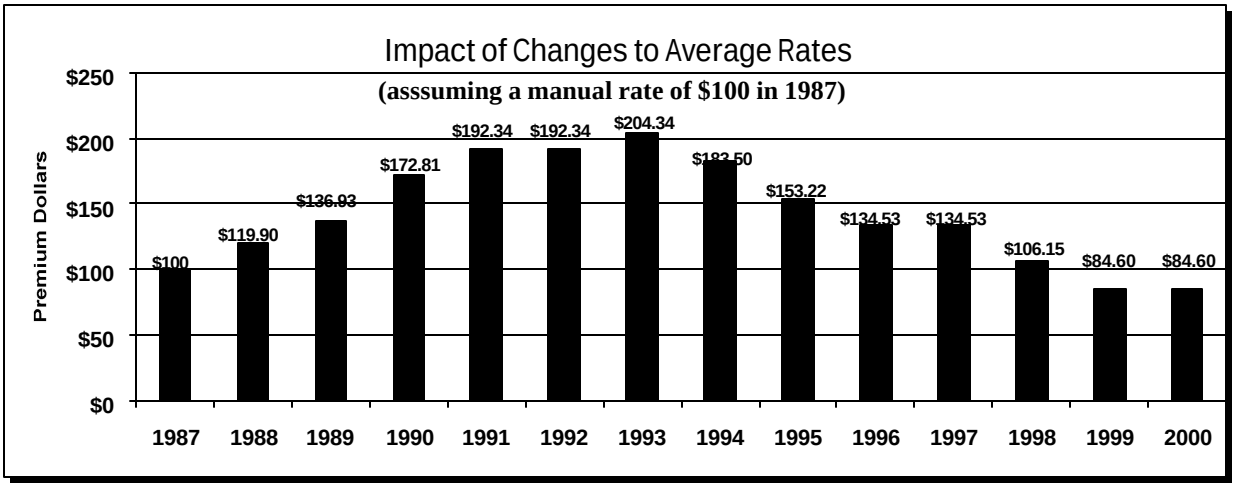
[46] If the Commissioner takes no action on a rate filing within six months, the rates are then deemed to be approved. If the Commissioner disapproves the rates, a new rate filing may be submitted. Finally, the Commissioner may order a specific rate reduction, if after a hearing it is determined that the current rates are excessive. Determinations by the Commissioner are subject to review by the Supreme Judicial Court.

[47] M.G.L. c.152, §53A(2).

[48] Rates were not retroactive to January 1 as they had been in other years, but took effect for those policies renewed or written on and after September 1, 1999.

The following chart illustrates the fluctuations in workers' compensation insurance rates since 1987. The chart displays how a company's premium would be affected by the average rate increases and decreases, assuming a company's premium was $100.00 in 1987 (with all other factors remaining the same - experience rating, discounts, etc.). The recent decision to decrease rates by 20.3%, coupled with previous declines in Massachusetts, has reduced workers' compensation rates 15.4% less than 1987 levels.

**Figure 24: Impact of Changes to Average Rates**




*NOTE: 1999 & 2000 Rates are for policies renewed or written on or after September 1, 1999.

**Deviations & Schedule Credits** - The Workers' Compensation Act allows individual carriers to seek permission from the Commissioner to use a percentage decrease from approved rates within certain classifications.[49] These percentage decreases are called "downward deviations." Schedule credits are also used in Massachusetts as a tool for competitive pricing, by allowing insurers to reward policyholders for good experience. These discounting techniques have become an important part of the Massachusetts insurance market. While open competition is not permitted, the use of deviations (and other alternatively priced policies) has encouraged carriers to compete for business on the basis of pricing.

Since the implementation of new rates on September 1, 1999, the Insurance Commissioner has approved 58 separate deviations and schedule credits. These discounts range from 5% to 38% off manual rates, depending upon the carrier and the classification.

[49] M.G.L. c.152, §53A(9).

# The Classification System

Workers' compensation insurance rates are calculated and charged to employers, according to categories of industries called classifications. Every employer purchasing workers' compensation insurance is assigned a basic classification determined by the nature of its operations. Standard exception classifications may then be assigned for low risk tasks performed within most companies (i.e. clerical work).

Classifications were developed on the theory that the nature, extent and likelihood of certain injuries are common to any given industry. Each classification groups together employers that have a similar exposure to injuries, so that overall costs of workers' compensation can be distributed equitably among employers. Without a classification system, employers in low risk industries would be forced to subsidize high-risk employers through higher insurance costs.

**Regulation of Classifications** - Classifications in Massachusetts are established by the Workers' Compensation Rating & Inspection Bureau (WCRIBM) subject to approval by the Commissioner of Insurance. Hearings are conducted at the Division of Insurance to determine whether classifications and rates are not excessive, inadequate or unfairly discriminatory and that they fall within a "range of reasonableness."[50]

**Basic Classifications** - Each business in the Commonwealth is assigned one "basic" classification that best describes the business of the employer. Once a basic classification has been selected, it becomes the company's "governing" classification, the basis for determination of premium.

Although most companies are assigned one governing classification, the following conditions determine when more than one basic classification should be used:

- the basic classification specifically states certain operations to be separately rated;
- the company is engaged in construction or erection operations, farm operations, repair operations, or operates a mercantile business, under which certain conditions allow for additional classifications to be assigned; or
- the company operates more than one business in a state.

**Standard Exception Classifications** - In addition to the 600 basic classification codes that exist in Massachusetts, there are 4 "standard exception classifications" for those occupations, which are common to virtually every business and pose lesser risk of worker injury. Employees who fall within the definition of a standard exception classification are not generally included in the basic classification. These low cost standard exception classifications are: Clerical Office Employees (Code 8810), Drafting Employees (Code 8810), Drivers, Chauffeurs and Their Helpers (Code 7380), and Sales-persons, Collectors or Messengers-Outside (Code 8742).

[50] M.G.L. c.152, §53A.

**General Inclusions and Exclusions** - Sometimes certain operations within a company appear to be a separate business. Most are included, however, within the scope of the governing classification. These operations are called *general inclusions* and are:

- Employee cafeteria operations;
- Manufacture of packing containers;
- Hospital or medical facilities for employees;
- Printing departments; and
- Maintenance or repair work.

Some operations of a business are so unusual that they are separately classified. These operations are called *general exclusions* and are usually classified separately. General exclusions are:

- Aircraft operation - operations involved with flying and ground crews;
- New construction or alterations;
- Stevedoring, including tallying and checking incidental to stevedoring;
- Sawmill operations; and
- Employer-operated day care service.

**Manual Rate** - Every classification has a corresponding manual rate that is representative of losses sustained by the industry. An employers' base rate is based on manual rate per $100 of payroll, for each governing and standard exception classification.

| Class Code | Governing Classification | Manual Rate | Payroll | Base Rate |
|---|---|---|---|---|
| 5188 | Automatic Sprinkler Installation & Drivers | $2.50 | $200,000 | $5,000 |

| Class Code | Standard Exception | Manual Rate | Payroll | Base Rate |
|---|---|---|---|---|
| 8810 | Clerical Employees | $.25 | $50,000 | $125 |

**Appealing a Classification** - When a new company applies for insurance, the broker or agent assigns a classification, which is audited by the insurance carrier at the end of the policy year. If the carrier determines the employer was misclassified, the employer is charged additional premium or receives a credit for the correct class. The WCRIBM is responsible for determining the proper classification for all insureds in Massachusetts. If an employer disagrees with its assigned classification, or believes a separate classification should be created, there is an appeal process made available by M.G.L. c.152, §52D. A formal appeal must be held with the WCRIBM's Governing Committee (for those insured in the Voluntary Market) or the Residual Market Committee (for those insured in the Assigned Risk Pool). The WCRIBM will send an auditor to the worksite and proceed to make a ruling on the classification in question. If reclassification is denied, an appeal can be made to the Commissioner of Insurance. A hearing officer will then be selected by the Commissioner to conduct an evidentiary hearing on the classification issue.

**Construction Industry** - In the construction industry alone, there are over 67 different classifications for the various types of construction or erection operation. Often, multiple classifications must be assigned to large general contractors who use different trades during the many phases of construction projects. Separate payrolls must be maintained

for separate classifications or else a construction company can be assigned to the highest rated classification that applies to the job or location where the operation is performed. The Massachusetts Construction Classification Premium Adjustment Program is a program that provides for a manual premium credit ranging from 5% to 25%, depending on average hourly wages paid to employees. Because a disparity exists between high and low wage construction employers (largely determined by the existence of a collective bargaining agreement), this program is designed to offset the higher premiums associated with larger payrolls and equalize workers' compensation costs.

## Premium Calculation

Premiums charged to employers in Massachusetts are dependent on several factors that are designed to measure each company's exposure to loss. Premium is based on uniform rates that are developed for each classification and modified according to the attributes of each employer. In return for payment of premiums, the insurance company will administer all workers' compensation claims and pay all medical, indemnity (weekly compensation), rehabilitation, and supplemental benefits due under the Workers' Compensation Act. The following is an overview of the premium calculation process.

**Manual Premium -** The first step in the premium calculation process is determination of manual premium. The manual premium is reflective of both the industry (manual rate) and size (payroll) of a company. The manual premium is calculated by multiplying the employer's manual rate by its annual payroll per $100.

**Manual Premium** = (Manual Rate x Payroll)/100

An employer's manual rate is assigned according to its classification. As explained in the prior section, every classification has a corresponding manual rate that reflects the industry's exposure to loss.

Once a corresponding manual rate has been established, exposure to loss for the particular employer must then be considered. In Massachusetts, this is determined by payroll. Payroll is a factor of an employers wage rate, the number of employees employed, and the number of hours worked. All other factors being equal, a firm with a large payroll has a greater exposure to loss than a firm with a smaller payroll. Furthermore, since indemnity benefits are calculated as a percentage of wages earned, payroll also reflects severity of potential loss.

**Standard Premium -** Once a manual premium has been determined, it is then multiplied by an experience modification factor to determine the standard premium.

**Standard Premium** = Manual Premium x Experience Modification Factor

Experience rating is a system of comparing the claims history of each employer against the average claims experience of all employers within the same classification.

An experience modification factor is calculated, which provides either a premium reduction (credit) or a premium increase (debit) to an insured's premium. For example, a modification of .75 results in a 25% credit or savings to the premium, while a modification of 1.10 produces a 10% debit or additional charge to the premium. When a modification of 1.00 (unity) is applied, no change to premium results.

The experience modification factor is determined on an annual basis, which is based on an insured's losses for the last three completed years.

For instance, two similar employers may have a manual rate of $25 per $100 of payroll, but the safety conscious employer (with fewer past claims) may have an experience modification factor of .80, thus adjusting his rate to $20 per $100 of payroll. The other employer, who is not as safety conscious, may have an experience modification factor of 1.20, which adjusts the company's rate to $30 per $100 of payroll.

**All Risk Adjustment Program** - In January 1990, the WCRIBM instituted the All Risk Adjustment Program (ARAP), calculated in addition to the experience modification factor. Its original purpose was to establish adequate premiums to encourage more insurers to write voluntary business. ARAP measures actual losses against expected losses, but it differs from the experience modification in that it measures severity and not frequency of claims. ARAP can add a surcharge up to 49% of an employer's experience modified standard premium.

## Premium Discounting

Insurance companies that provide workers' compensation coverage must factor in the various expenses involved with servicing insureds to determine appropriate premium levels. However, a problem occurs when pricing premiums for large policies; as the premium increases, the proportion required to pay expenses decreases. In an effort to compensate for these differences, insurance companies must provide a premium discount to large policy holders. The premium discount increases as the size of the policy premium increases, resulting in a premium that better reflects costs. In most states, policy holders are entitled to a premium discount if they are paying over $10,000 in premiums.

**Table 23: Percent of Premium Discount for Type A & B Companies**

| TYPE "A" COMPANIES | | | TYPE "B" COMPANIES | | |
|---|---|---|---|---|---|
| Layer of Standard Premium | | Percent of Premium Discount | Layer of Standard Premium | | Percent of Premium Discount |
| First | 10,000 | 0.0% | First | 10,000 | 0.0% |
| Next | 190,000 | 9.1% | Next | 190,000 | 5.1% |
| Next | 1,550,000 | 11.3% | Next | 1,550,000 | 6.5% |
| Over | 1,750,000 | 12.3% | Over | 1,750,000 | 7.5% |

**Source:** WCRIBM, A General Revision of Workers' Comp. Insurance Rates and Rating Values, pg. 590 (8/14/95).

## Deductible Policies

Since 1991, deductible policies can provide the advantages of a retrospective policy and self-insurance. Employers are responsible for paying from the first dollar incurred up to the deductible limit, either on a per claim basis or on an aggregate basis for claims in the policy year. The insurer pays all benefits and then seeks reimbursement from the employer up to the amount of the deductible.

**Table 24: Premium Reduction % Per Claim Deductible**

| PER CLAIM DEDUCTIBLE[51] *Effective May 1, 1996* | |
|---|---|
| **Medical and Indemnity Deductible Amount** | **Premium Reduction Percentage** |
| $ 500 | 3.0% |
| $1,000 | 4.2% |
| $2,000 | 6.2% |
| $2,500 | 7.1% |
| $5,000 | 10.6% |

**Source:** WCRIBM

**Table 25: Massachusetts Benefits Claim and Aggregate Deductible Program**

| MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM[52] | | | |
|---|---|---|---|
| **Estimated Annual Standard Premium** | **Claim Deductible Amount** | **Aggregate Deductible Amount** | **Premium Reduction Percentage** |
| 0 to $75,000 | $2,500 | $10,000 | 7.0% |
| $75,001 to $100,000 | $2,500 | $10,000 | 6.5% |
| $100,001 to 125,000 | $2,500 | $10,000 | 5.9% |
| $125,001 to $150,000 | $2,500 | $10,000 | 5.4% |
| $150,001 to $200,000 | $2,500 | $10,000 | 4.5% |
| over $200,000 | $2,500 | 5% of Estimated Annual Standard Premium | 4.3% |

**Source:** WCRIBM, A General Revision of Workers' Comp. Insurance Rates & Rating Values (8/14/95).

## Retrospective Rating Plans

Retrospective rating bases premium on an insured's actual losses calculated at the conclusion of the policy period. Therefore, the insured has greater control over its insurance costs by monitoring and controlling its own losses. Retrospective rating should not be confused with "experience rating." Both adjust premium based on an employer's loss history. Experience rating, however, adjusts premiums at the start of the policy period (to predict future losses), whereas retrospective rating adjusts premiums at the end of the policy period to reflect losses that actually occurred.

**The Formula** - Although retrospective premiums are determined by a complex formula, they are generally based on three factors: losses the employer incurs during a policy period; expenses that are related to the losses incurred; and basic premium. Incurred losses have historically included medical and indemnity losses, interest on judgments,

[51] Massachusetts Workers' Compensation and Employer's Liability Insurance.
[52] Massachusetts Workers' Compensation and Employer's Liability Insurance.

and expenses incurred in third-party recoveries.[53] A basic premium is necessary to defray the expenses that do not vary with losses and to provide the insurance company with a profit. To control the cost of the premium in extreme cases, the policies state that the premium cannot be less than a specific minimum and cannot exceed a stated maximum.

**Eligibility Requirements** - Eligibility for a retrospective rating plan is based upon a minimum standard premium. Eligibility for a one-year plan is an estimated standard premium of at least $25,000 per year, and for a three-year plan the estimated standard premium must be at least $75,000.[54] Although these eligibility standards exclude many small businesses, one of the biggest misconceptions is that retrospective plans are only for large employers and high-risk groups. In Massachusetts, more smaller employers are purchasing retrospective plans to lower premiums by controlling company losses.

**Benefits and Disadvantages** - Under the right circumstances, retrospective rating can benefit both the insurer and the policyholder. The policyholder benefits by paying a smaller premium at the beginning of the policy year. Because premium is determined by losses, retrospective plans reward those businesses that maintain effective loss control programs. If losses are low, the insured will pay less than standard premium.

However, there is a significant uncertainty regarding the final premium amount, since it is impossible to be precise in predicting the volume or severity of workplace accidents. An unexpected claim towards the end of a policy period can be detrimental to a company, if funds have not been set aside for the retro premium. Furthermore, there is little incentive for the insurance company to limit settlement costs, when they are able to recover payments made on claims brought against the policyholder.

## Dividend Plans

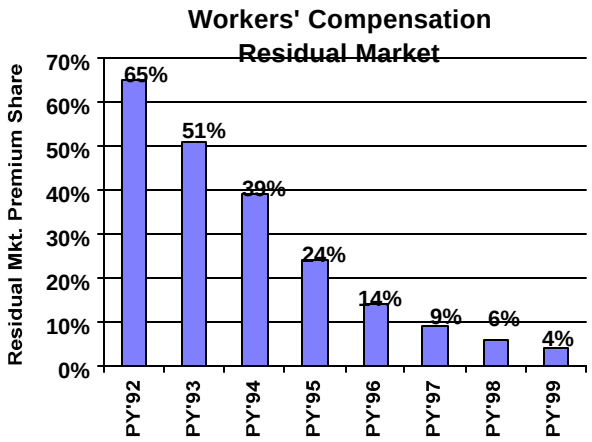
Offered as another means of reducing an employers insurance costs, dividend plans can provide the policy-owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year. The dividend is usually paid to the insured directly or by applying it to future premiums due. Regardless of how the payment is issued, dividends are non-taxable, since they are considered a return of premium.[55] Dividend plans may seem attractive to policy holders, but sometimes promise more than can be delivered. Insurer's are not legally bound to pay what they may have estimated a policy holder's return to be. Moreover, many insurers strategically calculate a dividend only once between 18 and 24 months after a policy's inception, and not always to the advantage of the insured.[56]

[53] "Retrospective Rating," Risk Financing, Supplement No. 46, May 1995: III.D.7.
[54] Workers' Compensation: Exposures, Coverage, Claims, Levick, Dwight E. Standard Publishing Corp., page 11-4.
[55] "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.
[56] "Thinking About the Work Comp Crisis," Merrit Risk Management Review, December 1991: 3.

# ASSIGNED RISK POOL

Any employer rejected for workers' compensation insurance can obtain coverage through the residual market, or Assigned Risk Pool. Administered by the Workers' Compensation Rating and Inspection Bureau (WCRIBM), the Assigned Risk Pool is the "insurer of last resort" and is required by law to provide coverage when an employer is rejected by at least two carriers within five business days. Very small employers and companies in high-risk classifications or having poor experience ratings often cannot obtain insurance in the voluntary market. This occurs when a carrier determines that the cost of providing insurance to a particular company is greater than the premium it can collect.

**Figure 25: Workers' Compensation Residual Market**




Preliminary figures for Policy Year 1999 indicate that 4% of every premium dollar is written in the residual market. This is an astounding statistic given that 64.7% of workers' compensation premium share is in the residual market during the 1992 policy year.[57]

Employers insured through the pool pay standard premium, and are not offered premium discounts, dividend plans, etc. The Commissioner of Insurance chooses the carriers that will administer the policies, called "servicing carriers." These carriers are paid a commission for servicing the policies, and are subject to performance standards and a paid loss incentive program.[58] These programs are designed to provide servicing carriers with incentives to provide loss control services to insureds.

[57] WCRIBM Special Bulletin No. 9-00 (August 28, 2000).

[58] The paid loss ratio incentive program provides up to a 9% bonus or penalty to the servicing carriers, depending upon the performance of losses. The performance standards program provides an additional bonus or penalty (between +2% to – 14% of the fee), based on four categories of on-site audit: (1) underwriting and audit, (2) loss control performance standards, (3) claim performance standards, and (4) financial reporting. However, because the percentage of premium in the residual market is so low, the Commissioner has determined that it is no longer feasible to conduct onsite performance standards audits. For this reason, the Commissioner suspended the program for 1997 and under new rules will make a yearly determination. (WCRIBM, Assigned Risk Pool Plan of Operation as amended by Decision and Order, Division of Insurance, Docket No. W97-19 (December 31, 1997)).

**Residual Market Loads** - Every insurance carrier licensed to write workers' compensation policies is required to be a member of the Assigned Risk Pool. Members are collectively responsible for underwriting pool policies, for bearing the risk of all losses, and are entitled to any profits generated. When the pool operates at a deficit, the members are subject to an assessment. Assessments are calculated in direct proportion to the amount of premium written in the voluntary market. This is called the Residual Market Load.

The Residual Market Load is incorporated into rates, and was a significant factor for employers to search out alternative risk financing options. Self insurance and self-insurance groups are not subject to residual market assessments.

The Residual Market Load is incorporated into manual rates. This residual market burden (percentage of each voluntary market dollar used to pay for the assigned risk pool) has significantly decreased over the past three years. Loss ratios have also continued to decline. The residual market loss ratio measures the amount of losses and expenses to the premiums written (roughly money out divided by money in). A loss ratio greater than 100% indicates that losses are greater than revenues (premiums). The expected residual market loss ratio for Policy Year 1999 is 60% with an estimated underwriting burden of -0.7%.[59]

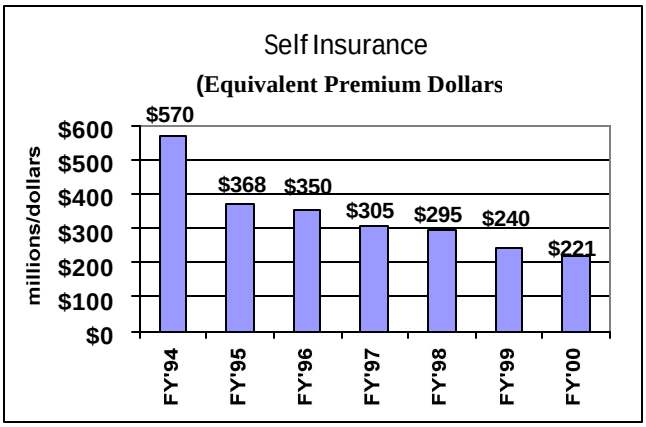
[59] WCRIBM Circular Letter No. 1852 (August 16, 2000).

# ALTERNATIVE RISK FINANCING METHODS

Self insurance and self insurance groups (SIGs) became an extremely popular device to control rising workers' compensation costs, when insurance rates rose so dramatically in the late 1980's and early 1990's. Much of the cost savings derived from avoidance of residual market loads incorporated into commercial insurance premiums to pay for the large assigned risk pool. Since 1993, insurance rates have decreased dramatically, making alternative risk financing measures less attractive. In recent years, employers have re-assessed cost savings associated with these programs, and many have turned to commercial insurance plans, most noticeably large deductible policies and retrospective rating plans.

## Self Insurance

**Figure 26: Self Insurance in MA - Premium Dollars**




The Division of Industrial Accidents strictly regulates self insured employers through its annual licensing procedures. For an employer to qualify to become self insured, it must post a surety bond of at least $100,000 to cover for losses that may occur (452 C.M.R. 5:00). This amount varies for every company depending on their previous reported losses and predicted future losses. The average bond, however, is usually over $1 million. Self insurance is generally available to larger employers with at least 300 employees and $750,000 in annual standard premium.[60] These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover incurred losses. In addition, employers who are self insured must purchase reinsurance of at least $500,000. Each self-insured employer may administer its own claims or engage the services of a law firm or a third party administrator (TPA) to handle claims administration. The office of insurance[61] evaluates employers every year to determine their continued eligibility and set a new bond amount.

**Table 26: Total Self-insured licenses in Massachusetts**

| | New Licenses | Total Licenses | Companies Covered |
|---|---|---|---|
| **FY'94** | 23 | 224 | 688 |
| **FY'95** | 11 | 227 | 734 |
| **FY'96** | 5 | 226 | 734 |
| **FY'97** | 5 | 206 | 417 |
| **FY'98** | 5 | 186 | 503 |
| **FY'99** | 6 | 174 | 464 |
| **FY'00** | 5 | 173 | 437 |

**Source:** DIA Office of Insurance

[60] 452 C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers.
[61] See Annual Report section on *DIA - Office of Insurance* for fiscal year 2000 statistics on self insurance.

# Self Insurance Groups

Companies in related industries may join forces to form a self insurance group (SIG). Regulated by the Division of Insurance, SIGs may include public employers, non-profit groups, and private employers in the same industry or trade association.[62]

As part of the workers' compensation reform package of 1985, SIGs were permitted in Massachusetts to provide an alternative to coverage in the assigned risk pool. Since that time, membership has been a popular alternative to commercial insurance because of the ability for members to manage their own claims. In addition, SIGs are generally able to reduce administrative costs from a fully insured plan. These savings result from reduced or eliminated commissions, premium taxes, etc.

*Table 27: Membership in W/C SIGs as of Jan. 1st*

**Membership in Workers' Compensation Self-Insurance Groups as of Jan. 1st**

| Year | Number of Groups | Number of Members |
|---|---|---|
| 1991 | 8 | N/A |
| 1992 | 21 | N/A |
| 1993 | 28 | N/A |
| 1994 | 27 | 2,300 |
| 1995 | 31 | 2,550 |
| 1996 | 32 | 2,700 |
| 1997 | 30 | 2,830 |
| 1998 | 26 | 2,880 |
| 1999 | 25 | 2,821 |
| 2000 | 24 | Unavailable |
| 2001 | 25 | Unavailable |

**Source:** Division of Insurance

Members of a self insurance group are assigned a classification and are charged manual rates approved by the Commissioner of Insurance for commercial insurance policies. Premium is calculated in the same manner, with manual rates adjusted by an experience modification factor and the All Risk Adjustment Program (ARAP).[63] Cost savings arise through dividends returned to members and deviated rates.

Companies who join self insurance groups rely heavily on the solvency and safety records of fellow members, since the insurance risks are spread amongst the group. If one of the employers in a group declares bankruptcy or suffers a catastrophic accident, the whole group must absorb the losses. In addition, all members share joint and several liability for losses incurred.

The first group was approved in 1987. After a few years of modest interest, five SIGs were formed in 1990 and 21 in 1992. As of January 1, 2001, there were 25 SIGs in the Commonwealth.

[62] According to Division of Insurance regulations, a SIG must have "five or more employers who are engaged in the same or similar type of business, who are members of the same bona fide industry, trade or professional association which has been in existence for not less than two years, or who are parties to the same or related collective bargaining agreements. (Div. of Insurance Regulations, 211 CMR 67.02).

[63] 211 CMR 67.09.

# INSURANCE FRAUD BUREAU

The Insurance Fraud Bureau is an insurance industry supported agency authorized by the Commonwealth to detect, prevent and refer for criminal prosecution suspected fraudulent insurance transactions involving all lines of insurance. [64] It was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.[65] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance.

## The Investigative Process

**Referrals** - Cases of suspected fraud for all types of insurance are generally referred to the IFB, either through an insurance carrier or through a toll-free hotline, which can be reached at: 800-32-FRAUD. In 1999, the IFB received 297 referrals regarding workers' compensation fraud.[66] Of these referrals, 98 (32%) were accepted for investigation.

**Evaluation** - Once a referral is received by the IFB, an investigative staff must evaluate each case within 20 working days. During this time, status letters are sent to the insurance companies indicating whether the case was referred to another agency or accepted for further investigation. A backlog has historically existed in investigations at this initial stage.

**Assigned Cases** - Once resources become available, a referral is assigned to an investigator and officially becomes a "case." In 1999, a total of 162 new cases were assigned to investigators dealing with workers' compensation fraud.

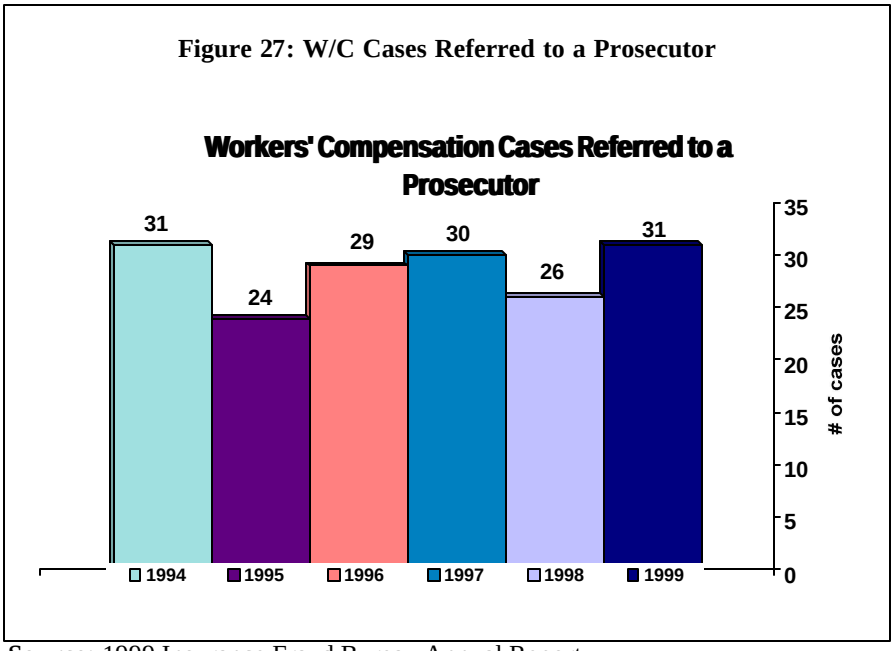
[64] The Insurance Fraud Bureau has its own Internet web site which can be found at http://www.ifb.org. The site is designed to inform the public on the activities and accomplishments of the IFB. The site also allows the general public to submit anonymous tips on suspected insurance fraud.

[65] M.G.L. St. 1990, c.338 as amended by St. 1991, c.398, §9

[66] Solicited referrals are included in this number.

**Prosecution** - After an investigator has completed their work on a case, it is either referred to a prosecutor (primarily the Massachusetts Attorney General's Office), transferred to another agency, or closed due to lack of evidence. In 1999, a total of 31 cases were referred to a prosecutor dealing with workers' compensation fraud.

**Figure 27: W/C Cases Referred to a Prosecutor**




**Source:** 1999 Insurance Fraud Bureau Annual Report

The types of workers' compensation cases that are investigated vary greatly. Fraud can be perpetrated by the employee, employer, medical provider, attorney and in some cases the insurance agent. The majority of IFB investigations, however, involve employee misconduct. IFB personnel investigate the following types of workers' compensation fraud:

> *Claimants with duplicate identities who worked while receiving workers' compensation benefits or who earned income from one or more employers and failed to disclose it; cases where subjects participated in physical activities wholly inconsistent with the disability claimed or whose injuries were fraudulently attributed to the workplace; premium evasion cases; phony death claims; and staged falls.*

While fraud continues to be a major concern for everyone involved in workers' compensation, the IFB and the Attorney General's Office continue to make great strides to curtail its perpetration. It is difficult to establish criminal intent in fraud cases, but the pursuit of these cases and publicizing any convictions will establish a precedent warning, to those who consider defrauding the workers' compensation system, that fraud will not be tolerated.